2008

Wyoming Medicaid/EqualityCare Annual Report

State Fiscal Year 2007

Wyoming Department of Health

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WYOMING EQUALITYCARE — SFY 2007 ANNUAL REPORT
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WYOMING MEDICAID/EQUALITYCARE —SFY 2007 ANNUAL REPORT INTRODUCTION

Annual Report Overview

Wyoming's Department of Health must frequently respond to questions from legislators, providers and others about Wyoming's Medicaid expenditures, utilization and reimbursement methodologies. The Annual Report is designed to assist in this process, providing timely information by service area and in the aggregate for the past two State Fiscal Years (SFYs).

The Annual Report provides an overview of Medicaid expenditures, recipients and eligibles for 19 Wyoming Medicaid service areas for SFYs 2006 and 2007.[1] The Report provides a summary of the reimbursement methodology for each service area and any recent changes. Table 1 lists the service areas analyzed.

The Report also includes an overview of Medicaid eligibility, individuals dually eligible for Medicare and Medicaid, a summary of expenditures, and information regarding eligibles and recipients for Medicaid and State-only funded foster care services. Appendix A provides detail about the data sources and calculations used in this Report. Appendix B describes the history of reimbursement methodology changes for each service area described in this report.

The reimbursement areas in this Report account for over 93 percent of Medicaid spending. There are expenditures for additional Medicaid services that are not included in this Report. For example, expenditures for the State Training School, the state's only ICF-MR, are excluded from this Report because the Division of Developmental Disabilities oversees the budget for those services.

With providers having to change to the new federal mandated National Provider Identifier (NPI) to submit claims, some providers held claims or were unable to file claims and as a result there were probably less claims and expenditures in May and June of 2007 than would have processed and as a result there was an increase in August 2007 of around $10 million from the same period last year. This may or may not be all directly to the vendor ID change.

[1]KidCare, the State's Child Health Insurance Program (CHIP) is not included in Medicaid, and is not discussed in this Report.

Table 1: Service Areas Included in SFY 2007 Annual Report

Service Areas	
Ambulance	Laboratory
Ambulatory Surgery Center (ASC)	Long-Term Care[2]
Comprehensive Outpatient Facility (CORF)	Mental Health and Substance Abuse[3]
Dental	Physician and Other Practitioners Paid by the Medicaid Physician Fee Schedule
Durable Medical Equipment, Prosthetic, Orthotic and Supply (DMEPOS)	Prescription Drug
End State Renal Disease (ESRD)	Radiology
Federally Qualified Health Center (FQHC)	Rural Health Clinic (RHC)
Home Health	Vision
Hospice	Waiver Habilitation[4]
Hospital[5]	

Overview of Wyoming Medicaid

EqualityCare, the chosen name of Wyoming's Medicaid program, provides financial assistance for health care services to individuals who qualify for one of four major eligibility categories. The eligibility categories are discussed in detail in Section 2 of this Report (Medicaid Eligibility).

[2] Includes long-term care waiver services, assisted living facility waiver services and nursing facility services.
[3] Includes Community Mental Health Centers (CMHCs), mental health professional, substance abuse, children's mental health waiver and residential treatment center (RTC) services.
[4] Includes adult, child and Acquired Brain Injury (ABI) waiver services.
[5] Includes inpatient and outpatient hospital services.

The federal government and the State jointly fund and administer the Wyoming Medicaid program. The federal government matches Wyoming's spending for covered services on an open-ended basis. The federal match rate, known as the federal medical assistance percentage (FMAP) ranges from state to state and is inversely related to state per capita income. Nationwide, Federal Fiscal Year (FFY) 2007 Medicaid FMAPs ranged from 50 percent to 75.89 percent.[6] Wyoming's FFY 2007 FMAP was 52.91 percent.[7]

Wyoming Medicaid also provides assistance to low-income individuals who qualify for both Medicaid and Medicare ("dual eligibles"), including helping them pay for their portion of their Medicare costs, and nursing facility costs if they reside in an institution. Some services for this population are funded only by Wyoming Medicaid. For other services, Medicare is the primary payer and Wyoming Medicaid provides additional payments. Claims for these services are referred to as crossover claims. Section 5 of the Annual Report (Medicaid and Medicare Dual Eligibles) provides more information on this population.

The following mandatory health care services are covered by Wyoming Medicaid, as required by the U.S. Department of Health Centers for Medicare and Medicaid Services (CMS):

- Physician
- Rural Health Clinic (RHC) services
- Laboratory and x-ray
- Nurse-midwife
- Inpatient and outpatient hospital
- Certified pediatric nurse practitioner or family nurse practitioner
- Nursing facility
- Early and periodic screening, diagnostic and treatment (EPSDT)
- Home health care
- Family planning and supplies
- Transportation[8]
- Federally Qualified Health Center (FQHC)

Wyoming Medicaid also provides a number of optional services to some Medicaid beneficiaries, including:

- Dental
- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- End stage renal disease (ESRD)
- Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
- Mental health and substance abuse
- Prescription drugs
- Targeted case management
- Vision
- Waiver habilitation

The Department administers the Medicaid program on a day-to-day basis, which includes the following functions:

- Providing oversight of eligibility functions
- Determining how much it will pay for services, from whom it will purchase services, and monitoring the quality of those services
- Processing claims
- Ensuring that funds are not spent improperly or fraudulently

The federal government, specifically CMS, is responsible for other administrative activities of the Medicaid program, including:

- Processing state Medicaid plan amendments and waiver requests, and monitoring and enforcing state compliance with amendments and waivers
- Interpreting federal statutory requirements for states, providers and beneficiaries

[6] Fifty percent is the minimum federal match.
[7] National Conference of State Legislatures, "Federal Medical Assistance Percentages (FMAP) FY 2007 Calculations)". Available online: http://www.ncsl.org/statefed/health/FMAPfy07.htm.

[8] Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.

- Ensuring the efficient administration of the program by state agencies
- Ensuring that funds are not spent improperly or fraudulently

The Wyoming Medicaid State Plan is the official statement describing the scope of Wyoming's Medicaid program. The State Plan includes provisions required by Section 1902 of the Social Security Act to receive federal funding, including methods of administration, eligibility guidelines, covered services, quality control and provider reimbursement. CMS must approve any changes made by Wyoming Medicaid to the State Plan, referred to as state plan amendments. The Wyoming Administrative Rules and Department manuals and memorandum provide additional information on the regulations and requirements governing Wyoming's Medicaid program.[9,10]

A state can also submit a Medicaid waiver application to CMS to request to waive certain federal Medicaid requirements. These waivers allow states more flexibility in their Medicaid programs. Wyoming currently has six Medicaid waivers:

- Children's Mental Health Waiver for Children with Severe Emotional Disturbance
- Home- and Community- Based Services (HCBS) Waiver Program for Children with Developmental Disabilities
- HCBS Waiver Program for Adults with Developmental Disabilities
- Acquired Brain Injury HCBS Waiver Program
- Long-Term Care HCBS Waiver for aged and physically disabled individuals
- Assisted Living Facility Waiver for aged and physically disabled individuals

These waivers are described in more detail in Section 3 of the Report (Service Areas).

The Department collaborates with a number of other Wyoming State agencies that also provide services to Medicaid recipients. Some of the agencies that Wyoming Medicaid frequently works with include:

- Mental Health and Substance Abuse Services Division
- Department of Education
- Department of Family Services
- Developmental Disabilities Division

Overview of Trends in Eligibles and Recipients

Medicaid eligibles may gain and lose eligibility several times in one SFY. Individuals who are eligible at one point in time (i.e., at the end of a SFY) may not be eligible at other times of the year. Other individuals may retain eligibility throughout the year. As such, the unduplicated count of Medicaid eligibles for a complete SFY (regardless of how long they were eligible) will be greater than a point-in-time count of the number of Medicaid eligibles. A point-in-time estimate of Medicaid eligibles provides a measure of the average number of Medicaid recipients on any given day while an unduplicated count across a SFY provides a measure of the number of individuals served by the Medicaid program.

The number of Medicaid eligibles has decreased slightly over the last SFY as shown in the following table. The number of eligibles eligible as of June 30, 2007 (point in time) decreased by three percent as compared to a two percent decrease for the unduplicated count of eligibles for the entire SFY 2007.

[9] Wyoming Secretary of State, "Rules and Regulations". Available online: http://soswy.state.wy.us/Rule_Search_Main.asp
[10] ACS, "Billing Manuals" and "Bulletins and Newsletters". Available online: http://wyequalitycare.acs-inc.com/index.html

Table 2: Summary of Medicaid Eligibles

SFY	Eligibles (As of 6/30/07)	Eligibles (Unduplicated Count for SFY 2007)
2006	58,368	80,972
2007	56,411	79,510

Table 3 displays an unduplicated count of recipients in SFY 2007 by service area. This table does not include a total number of recipients because individuals may receive services from multiple service areas. Therefore, summing the number of recipients would have the inadvertent effect of "double counting" a recipient if the recipient received more than one service.

From SFY 2006 to SFY 2007, the number of recipients decreased for all but the shaded service areas shown in the following table. Hospice and CORF services experienced the largest percentage increase in recipients; however, the number of recipients these increases represent is relatively small.

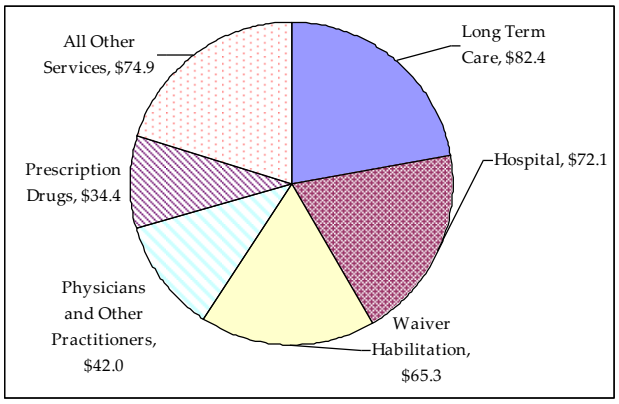
Table 3: Number of Medicaid Recipients by Service Area in SFY 2007 and Percentage Change from SFY 2006, Arrayed by Number of Recipients

Service Area	Number of Recipients SFY 2007	Percentage Change from SFY 2006
Physician and Other Practitioners	50,490	-3
Prescription Drugs	45,894	-8
Hospital	39,779	-7
Outpatient	30,125	-6
Inpatient	9,654	-8
Dental	20,532	7
Radiology	13,640	-7
Vision	10,301	-10
Laboratory	8,154	-6
Mental Health and Substance Abuse	7,542	3
Long-Term Care	4,033	-3
DMEPOS	3,995	-9
RHC	3,942	-8
FQHC	3,929	-1
Ambulance	2,283	-8
ASC	1,838	<1
Waiver Habilitation	1,239	3
Home Health	560	-1
Hospice	104	28
CORF	42	68
ESRD	21	5

Overview of Expenditure Trends

Expenditures for the Medicaid services described in this Annual Report, excluding crossover claims for dual eligibles, totaled $376 million in SFY 2007, the majority of which can be attributed to long-term care, hospital and waiver habilitation services, as illustrated in the below figure.[11,12]

Figure 1: Medicaid Expenditures – SFY 2007



Expenditures for all Medicaid services covered in the Report decreased three percent from SFY 2006 to SFY 2007, as illustrated in Table 4. This decrease appears to result from the decrease in the number of Medicaid eligibles and recipients, because the per eligible expenditures between SFYs 2006 and 2007 stayed relatively constant (less than one percent decrease).

Three of the five service areas with the highest expenditures experienced reduced expenditures between SFYs 2006 and 2007. Prescription drug expenditures decreased by 24 percent as compared to hospital expenditures at 15 percent and long-term care at three percent. Radiology, laboratory and RHC expenditures also decreased from SFY 2006 to 2007; all

[11] Total expenditures include QRA payments for inpatient and outpatient hospital and exclude disproportionate share hospital payments. Without QRA payments, total expenditures were $371 million. Total expenditures include expenditures for dually eligible (Medicare and Medicaid) individuals when there was no Medicare payment for the entire service.

[12] In SFY 2007, expenditures for Medicare crossover claims totaled $9.4 million.

other service areas analyzed experienced increased expenditures.

As shown in Table 5 on the following page, all service areas experienced an increase in expenditures per recipient, with the exception of hospital, prescription drugs, radiology, RHCs and laboratory.

There was substantial variation in the percent change in expenditures per recipient from SFY 2006 to SFY 2007 among the eight service areas with the highest expenditures per recipient. Figure 2 displays the change in expenditures per recipient for waiver habilitation, ESRD, long- term care, hospice, hospital, mental health and substance abuse, home health and radiology services. Of these service areas, expenditures per recipient increased the most for ESRD from SFY 2006 to SFY 2007.

The service areas with the highest expenditures per recipient (waiver habilitation, ESRD and long-term care services) all experienced increases in expenditures per recipient from SFY 2006 to SFY 2007, ranging from less than one percent (long-term care) to a little more than 44 percent (ESRD). Mental health, DMEPOS, home health, hospice and ambulance services also experienced notable increases.

Expenditures per eligible followed similar trends, as illustrated in Table 6. All service areas experienced an increase in expenditures from SFY 2006 to 2007, with the exception of hospital, prescription drugs, radiology, and laboratory services.

Table 4: Percentage Change in Total Expenditures for Service Areas – SFYs 2006-2007, Arrayed by SFY 2007 Expenditures

Service Area	SFY 2007 Expenditures (in millions $)	Percentage Change
Long-Term Care	$ 82.4	-3
Hospital	75.5	-15
Inpatient	*60.5*	*-15*
Outpatient	*16.9*	*-13*
Waiver Habilitation	65.3	7
Physician and Other Practitioner	42.0	4
Prescription Drug	34.4	-24
Mental Health and Substance Abuse	32.6	24
Radiology	14.8	-14
Dental	8.5	11
DMEPOS	3.5	10
FQHC	3.2	10
Vision	2.3	4
Ambulance	2.0	25
Home Health	2.0	27
ASC	1.8	3
RHC	1.5	-11
ESRD	0.9	52
Hospice	0.9	70
Laboratory	0.9	-8
CORF	0.03	84
Total Expenditures[13]	**$ 376.48**	-3

[13] Due to rounding, the total of all service areas in the table will not equal total Medicaid expenditures.

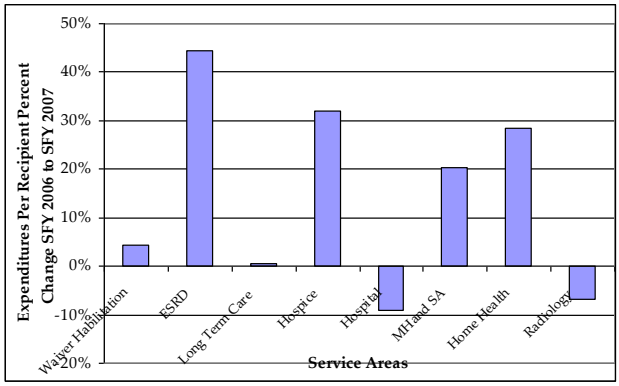
Table 5: Percentage Change in Expenditures Per Recipient – SFYs 2006-2007 Arrayed by Expenditures per Recipient

Service Area	SFY 2007 Expenditures Per Recipient	Percentage Change in Expenditures Per Recipient from SFY 2006
Waiver Habilitation	$ 52,694	4
ESRD	43,955	44
Long-Term Care	20,433	<1
Hospice	8,594	32
Hospital	1,647	-9
Inpatient	*6,270*	-8
Outpatient	*562*	-7
Mental Health and Substance Abuse	4,326	20
Home Health	3,481	28
Radiology	1,085	-7
ASC	988	3
DMEPOS	878	20
Ambulance	877	36
Physician and Other Practitioner	833	7
FQHC	812	12
Prescription Drug	749	-17
CORF	669	9
Dental	415	3
RHC	378	-3
Vision	226	13
Laboratory	104	-1

Table 6: Percentage Change in Expenditures Per Eligible by Service Area – SFYs 2006-2007, Arrayed by Expenditures per Eligible

Service Area	SFY 2007 Expenditures Per Eligible	Percentage Change in Expenditures Per Eligible from SFY 2006
Long-Term Care	$ 1,036	-1
Hospital	974	-13
Hospital - Inpatient	761	-13
Hospital - Outpatient	213	-11
Waiver Habilitation	821	9
Physician	529	6
Prescription Drug	432	-22
Mental Health and Substance Abuse	410	26
Radiology	186	-12
Dental	107	13
DME	44	12
FQHC	40	13
Vision	29	4
Ambulance	25	28
Home Health	25	29
ASC	23	5
RHC	19	-9
ESRD	12	54
Hospice	11	73
Lab	11	-6
CORF	<1	87

Figure 2: Percentage Change in Expenditures Per Recipient – SFYs 2006-2007, for Selected Service Areas



The remainder of this Report provides details regarding recipients and expenditures for each of the service areas described in this introduction. Additionally, the Report includes sections describing recipients and expenditures for foster care, Medicaid and Medicare dual eligibles and for each of the eligibility categories.

Overview of Wyoming Medicaid Eligibles

Wyoming Medicaid eligibility is generally based on family income and to a lesser extent, assets or health care needs. Federal statutes define more than fifty groups of individuals who may qualify for Medicaid coverage. There are four major categories of Medicaid eligibility in Wyoming:

- Children
- Pregnant Women
- Family Care Adults
- Aged, Blind and Disabled

In addition to these four major categories, Wyoming extends Medicaid eligibility to selected special groups, employed individuals with disabilities, individuals in Medicare Savings Programs and non-citizens with medical emergencies. We describe these eligibility categories in more detail below.

Eligibility for some categories is determined using Federal Poverty Level (FPL) guidelines.[14] Eligibility for other categories is determined by Supplemental Security Income (SSI) standards.[15]

Childless adults who do not fit into one of the eligibility categories described below are not covered regardless of income or assets.

Children
The following groups of children are eligible for Medicaid:

- Newborns are automatically eligible if the mother is Medicaid-eligible at the time of the birth.
- Low-income children are eligible if family income is below 100 percent of the FPL or 133 percent of the FPL, depending on age of the child.[16]
- Family Care children are eligible when a caretaker is determined eligible (i.e., family income is below the 1996 Family Care Standard).[17]
- Foster care children in Department of Family Services (DFS) custody are eligible, including some children who enter subsidized adoption or who age out of foster care when they become 21 years old.

Pregnant Women
The following groups of pregnant women are eligible for Medicaid:

- Pregnant women are eligible if family income is below 133 percent FPL. Women with income below the 1996 Family Care Standard must cooperate in establishing paternity for the baby so Medicaid can pursue medical support
- Presumptive eligibility allows for coverage of outpatient services for 45 days pending Medicaid eligibility determination[18]

Family Care Adults
Family Care adults (caretaker relatives with a dependent child) are eligible if family income is below the 1996 Family Care Standard.

Aged, Blind and Disabled (AB and D)
The following groups of AB and D individuals are eligible for Medicaid:

- SSI and SSI- related
  - SSI – A person receiving SSI automatically qualifies for Medicaid

[14] The 2007 FPL income standard is $851 per month for a family of one, $1,141 for a family of two, $1,431 for a family of three and $1,721 for a family of four.
[15] For calendar year 2007, the SSI standard was $623 per month for an individual and $943 per month for a couple.
[16] The income eligibility guidelines listed are for the 2007 federal poverty guidelines.
[17] The Family Care Standard established in 1996 is $362 per month for a family of one, $512 for a family of two, $590 for a family of three and $659 for a family of four.
[18] Presumptive eligibility for pregnant women allows immediate, temporary Medicaid coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy for low-income, pregnant patients, pending their formal Medicaid application.

  - SSI-related – A person no longer receiving SSI payment may be eligible using SSI criteria
- Institution – Residents of the following institution categories are eligible up to 300 percent of the SSI standard. Individuals do not have to be eligible for SSI.
  - Nursing Home
  - Hospital
  - Hospice
  - ICF/MR (State Training School)
  - WY State Hospital – Age 65 and older
- Home and Community Based Waiver – Individuals in the State's six waiver programs are eligible up to 300 percent of the SSI standard. Individuals do not have to be eligible for SSI.

Additionally, there are several other categories of eligibility as listed below.

Special Groups
The following special groups are eligible for Medicaid:

- Breast and Cervical Cancer Treatment Program – Uninsured women diagnosed with breast or cervical cancer are eligible for Medicaid if their income is below 250 percent of the FPL.
- Tuberculosis (TB) Program – Individuals diagnosed with tuberculosis are income eligible based on special income standards specific to the TB program.

Employed Individuals with Disabilities
Employed individuals with disabilities are eligible for Medicaid if their income is under 300 percent of the SSI standard using unearned income. Employed individuals with disabilities must pay a premium. Individuals do not have to be eligible for SSI.

Medicare Savings Programs
The following groups of Medicare eligibles are eligible to receive premium and cost sharing assistance from Medicaid:

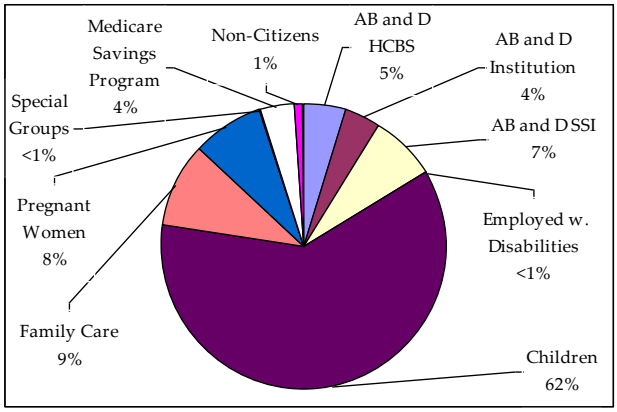
- Qualified Medicare Beneficiaries are income eligible under 100 percent of the FPL; Medicaid pays for Medicare premiums, deductibles and cost sharing.
- Specified Low Income Beneficiaries are income eligible under 135 percent of the FPL; Medicaid pays for Medicare premiums only.

Non-Citizens with Medical Emergencies
A non-citizen who meets all eligibility factors of a Medicaid group except for citizenship and social security number is eligible for emergency services.

Medicaid Eligibles and Recipients by Eligibility Category

There were 79,510 unduplicated Medicaid eligibles in SFY 2007, a two percent decrease from SFY 2006. Almost two-thirds of these eligibles (64 percent) are children, as displayed in the following figure.

Figure 1: Medicaid Eligibility by Program Category – SFY 2007



From SFY 2006 to 2007, the number of eligibles decreased slightly in most eligibility categories, with the exception of Non-Citizens with Medical Emergencies, Special Groups, AB and D HCBS and Employed Individuals with Disabilities. Table 1 on the following page provides additional detail

The number of dual eligibles stayed approximately the same from SFY 2006 to SFY 2007 – 8,480 dual eligibles in SFY 2006 as compared to 8,556 in SFY

2007. Section 5 of the Annual Report provides more information on this population.

Table 1: Percentage Change in Eligibles by Eligibility Category for SFYs 2006-2007, Arrayed by SFY 2007 Eligibles

Eligibility Category	SFY 2006 Eligibles	SFY 2007 Eligibles	Percentage Change from SFY 2006
Children	51,557	50,692	-2
AB and D Total	13,755	13,550	-2
AB and D SSI	6,208	6,134	-1
AB and D HCBS	3,793	3,991	5
AB and D Institution	3,737	3,424	-8
Family Care	8,598	7,875	-8
Pregnant Women	6,723	6,666	-1
Other Total	4,366	4,248	-3
Medicare Savings Program	3,283	3,085	-6
Non-Citizens with Medical Emergencies	886	925	4
Special Groups	184	184	0
Employed Individuals with Disabilities	13	54	315
Total Eligibles[19]	**80,972**	**79,510**	**-2**

[19] The total eligibles number in Table 1 is the unduplicated count of eligibles in each eligibility category for the SFY. The sum of eligibles by category listed in Table 1 will differ from the number of total unduplicated eligibles in SFY 2007 because eligibles may be counted in more than one eligibility category.

Consistent with trends in the number of eligibles, the number of recipients decreased slightly from SFY 2006 to SFY 2007 for all eligibility categories, with the exception of Medicare Savings Program, AB and D HCBS waiver, Non-Citizens with Medical Emergencies and Employed Individuals with Disabilities.[20] As shown in Table 2, the largest increase in recipients was 150 percent for the Employed Individuals with Disabilities category, although this represents an increase of only 24 recipients.

Table 2: Percentage Change in Recipients by Eligibility Category for SFYs 2006-2007, Arrayed by SFY 2007 Recipients

Eligibility Category	SFY 2006 Recipients	SFY 2007 Recipients	Percentage Change from SFY 2006
Children	44,406	43,692	-2
AB and D Total	13,122	12,881	-2%
AB and D SSI	5,604	5,509	-2
AB and D HCBS	3,929	4,083	4
AB and D Institution	3,589	3,289	-8
Pregnant Women	6,906	6,842	-1
Family Care	7,028	6,457	-8
Other Total	2,033	2,488	22
Medicare Savings Program	1,325	1,746	32
Non-Citizens with Medical Emergencies	507	522	3
Special Groups	185	180	-3
Employed Individuals with Disabilities	16	40	150

[20] The number of recipients for each Medicaid eligibility category is determined as an unduplicated count for the entire SFY for each service area.

Expenditures by Eligibility Category

Nineteen percent of eligibles – those in the AB and D population – accounted for almost two-thirds of Medicaid expenditures in SFY 2007, as illustrated in the figures below. Conversely, children represented approximately two-thirds of Medicaid eligibles in SFY 2007 yet accounted for only slightly more than a quarter of Medicaid expenditures.

Figure 2: SFY 2007 Medicaid Expenditures Compared to Number of Eligibles

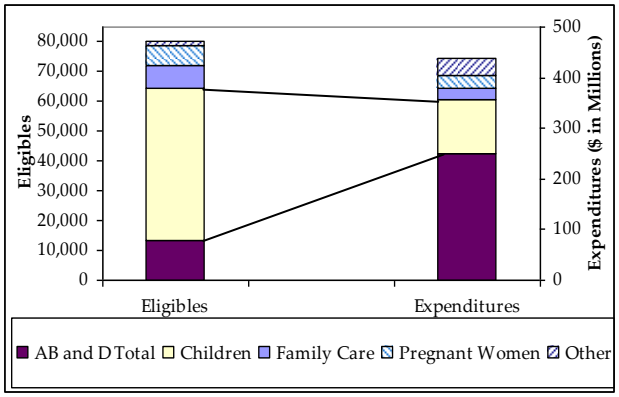
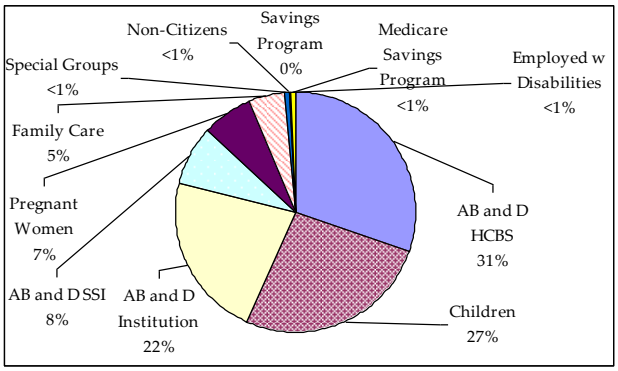


Figure 3: Percentage of SFY 2007 Medicaid Expenditures by Eligibility Category



As shown in the following table, the subcategories with the largest percentage increase in expenditures from SFY 2007 to 2006 were the subcategories with relatively low expenditures: Medicare Savings Program, Non-US Citizens with Medical Emergencies and Employed Individuals with Disabilities. The eligibility subcategory with the highest expenditures, AB and D HCBS Waiver, experienced a slight increase in expenditures.

Table 3: Percentage Change in Total Expenditures for Eligibility Categories – SFYs 2006-2007 Arrayed by SFY 2007 Expenditures

Eligibility Category	SFY 2007 Expenditures (in millions $)	SFY 2007 Expenditures (in millions $)	Percentage Change from SFY 2006
AB and D Total	$ 264.0	$ 249.0	-2
AB and D HCBS	120.3	124.6	4
AB and D Institution	105.8	91.2	-14
AB and D SSI	37.9	33.3	-12
Children	108.9	108.1	-1
Pregnant Women	26.1	27.4	5
Family Care	22.4	20.9	-7
Other Total	3.8	5.3	39
Medicare Savings Program[21]	.9	1.8	99
Special Groups	1.4	1.6	15
Non-Citizens with Medical Emergencies	1.3	1.6	28
Employed Individuals with Disabilities	0.2	0.3	28
Total	**$ 424.3**	**$ 409.3**	**-4**

As illustrated in the table on the following page, expenditures per Medicaid recipient also varied by eligibility category and subcategory. Expenditures

[21] Expenditures for Medicare Savings program recipients are not included in the total expenditures discussed in the introduction. Expenditures for this group are also not included in the expenditures by service area.

for Children were the lowest at $2,475 per recipient, and increased only slightly from SFY 2006 to SFY 2007 (one percent). Expenditures for AB and D were highest at $19,333 per recipient and decreased four percent from SFY 2006 to SFY 2007.

Expenditures for AB and D HCBS waiver recipients were $30,509 and increased negligibly from SFY 2006 to SFY 2007.

The largest increase in per recipient expenditures from SFY 2006 to SFY 2007 was for Medicare Savings Program (51 percent). The largest decrease from SFY 2006 to SFY 2007 was 49 percent for Employed Individuals with Disabilities.

Table 4: Percentage Change in Per-Recipient Expenditures by Eligibility Categories – SFYs 2006-2007 Arrayed by SFY 2007 Per-Recipient Expenditures

Eligibility Category	SFY 2006 Expenditures Per Recipient	SFY 2007 Expenditures Per Recipient	Percentage Change from SFY 2006
AB and D - Total	$ 20,118	$ 19,333	-4
AB and D HCBS	30,629	30,509	<1
AB and D Institution	29,472	27,714	-6
AB and D SSI	6,758	6,046	-10
Children	2,453	2,475	1
Pregnant Women	3,782	4,011	6
Family Care	3,185	3,240	2
Other Total	23,879	19,861	-17
Special Groups	7,629	9,018	19
Employed Individuals with Disabilities	13,063	6,699	-49
Non-Citizens with Medical Emergencies	2,493	3,098	24
Medicare Savings Program	694	1,046	51

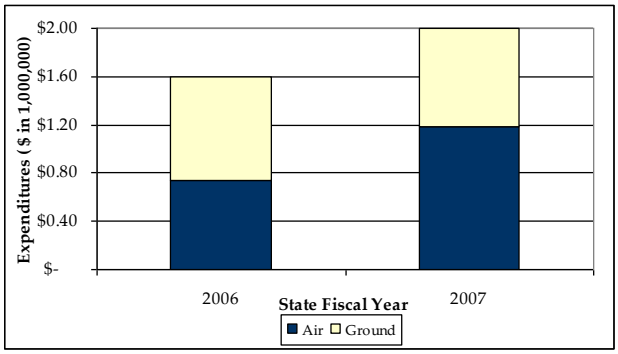
Description

Ambulance services comprise emergency ground and air transportation and limited non-emergency ground transportation.

Expenditures

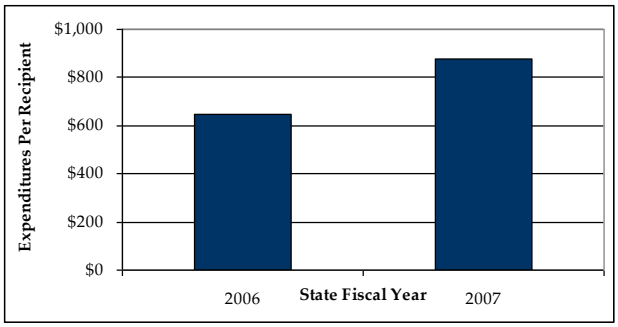
Ambulance expenditures totaled $2.0 million in SFY 2007, an increase of 25 percent from SFY 2006. Total ground ambulance expenditures were $0.82 million in SFY 2007, a decrease of five percent from SFY 2006, and total air ambulance expenditures were $1.18 million in SFY 2007, an increase of 60 percent from SFY 2006, as shown in the following figure. Total ambulance expenditures were one percent of total Medicaid expenditures in SFY 2007.

Figure 1: Total, Ground and Air Ambulance Expenditures — SFYs 2006-2007



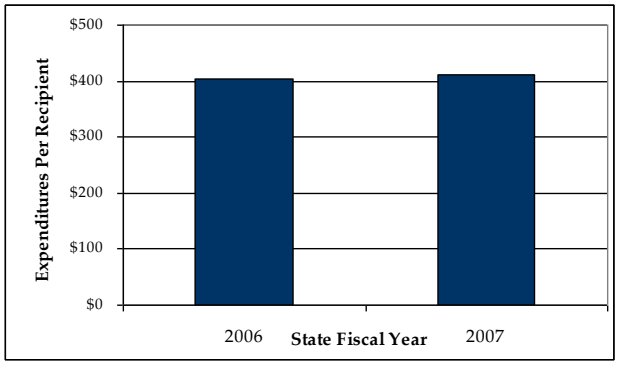
Ambulance expenditures per recipient increased by 36 percent from $645 per recipient in SFY 2006 to $877 per recipient in SFY 2007, and as shown in the following figure.

Figure 2: Ambulance Expenditures Per Recipient — SFYs 2006-2007



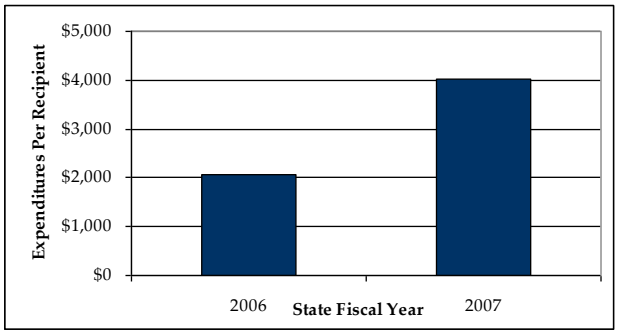
Ground ambulance expenditures per recipient increased slightly by two percent from $404 per recipient in SFY 2006 to $411 per recipient in SFY 2007, as shown in the following figure.

Figure 3: Ground Ambulance Expenditures Per Recipient — SFYs 2006-2007



Air ambulance expenditures per recipient increased by 94 percent from $2,066 per recipient in SFY 2006 to $4,011 per recipient in SFY 2007, and as shown in the figure on the following page. The increase in air ambulance expenditures per recipient may be due to a recent rate increase for air mileage as described on the following page.

Figure 4: Air Ambulance Expenditures Per Recipient — SFYs 2006-2007



The tables following this narrative provide detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid pays the lower of the Medicaid fee schedule or the provider's usual and customary charges for ambulance services. Wyoming Medicaid established a fixed fee schedule amount for transport and makes separate payments for mileage and disposable supplies. There are separate fee schedules for basic life support (ground), advanced life support (ground), additional advanced life support (ground) and air ambulance.

Effective January 1, 2006, Wyoming Medicaid updated the fee schedule for air ambulance codes and increased air ambulance rates from $7.00 to $11.20 per mile.

Current Issues

Providers indicated that rates are not sufficient, in particular because Wyoming Medicaid, like Medicare and other Medicaid programs, prohibits billing for unloaded mileage.[22] As a result, providers have expressed reluctance to transport Medicaid recipients over long distances since Wyoming Medicaid will not reimburse them for the return trip.

Provider concerns as well as cost trends may warrant a review of the costs of ambulance services by Wyoming Medicaid if access issues are noted.

[22] Wyoming Medicaid Rules, Chapter 15, Section 9.l. Unloaded mileage is defined as mileage logged when there is no patient on board the ambulance.

Table A: Total Ambulance Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 1,596,788	2,475	$ 645
2007	2,001,480	2,283	877
Percent Change SFYs 2006-2007	25.3	-7.8	35.9

Table B: Ground Ambulance Only Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 856,077	2,116	$ 404
2007	816,537	1,988	411
Percent Change SFYs 2006-2007	-4.6	-6.1	1.6

Table C: Air Ambulance Only Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 740,711	359	$ 2,066
2007	1,184,943	295	4,011
Percent Change SFYs 2006-2007	60.0	-17.6	94.2

AMBULATORY SURGERY CENTER

Description

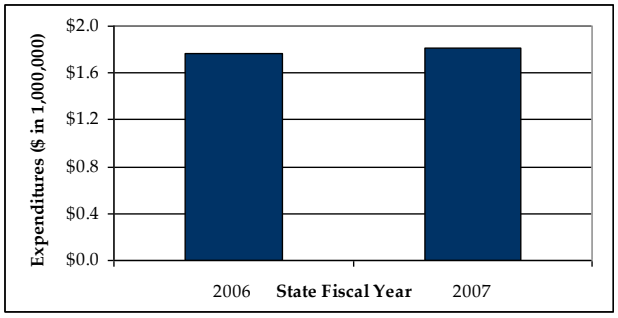
Services provided by freestanding Ambulatory Surgery Centers (ASC) are those that do not require overnight inpatient hospital care. These services encompass all surgical procedures covered by Medicare and additional surgical procedures that Wyoming Medicaid approves for provision as outpatient services.

ASCs provide services that can also be provided in an outpatient hospital setting. This section will describe ASC expenditure data as well as compare ASC and outpatient hospital expenditures and utilization to identify key trends in service delivery.

Expenditures

Expenditures for ASCs totaled $1.82 million in SFY 2007, an increase of 2.8 percent from SFY 2006, as shown in the following figure. ASC expenditures were less than one percent of total Medicaid expenditures in SFY 2007.

Figure 1: ASC Expenditures — SFYs 2006-2007



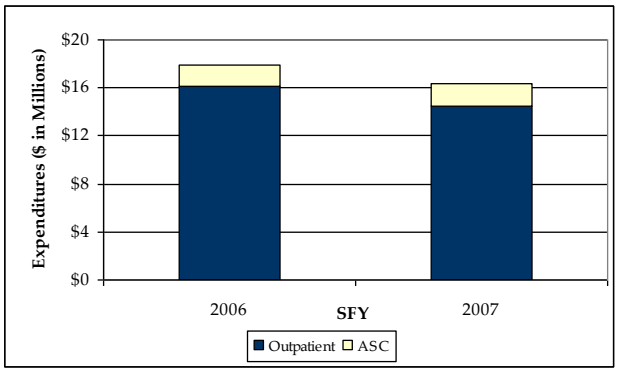
Most of these expenditures were associated with ASC groups 2 and 3 (61 percent and 20 percent of ASC expenditures). As shown in the following table, most ASC services paid for by Medicaid fall into the less costly payment groups.

Table 1: ASC SFY 2007 Expenditures by ASC Grouping

ASC Grouping	SFY 2007 Expenditures[23]	Percent of Total ASC Expenditures	Calendar Year 2007 Rate
Group 1	$ 108,782	6	$ 300
Group 2	1,198,991	61	401
Group 3	382,967	20	459
Group 4	160,896	8	567
Group 5	41,869	2	645
Group 6	16,706	1	743
Group 7	14,804	1	896
Group 8	28,769	1	876

Procedures performed in an ASC may be similar to those provided in an outpatient hospital setting. Total outpatient hospital and ASC expenditures were $16 million in SFY 2007, a decrease of 13 percent from $18 million in SFY 2006. ASC expenditures made up 11 percent of these total expenditures in SFY 2007, a small increase from 10 percent in SFY 2006, as shown in the following figure. Wyoming Medicaid payments as a percent of charges were slightly higher for ASCs in SFY 2007; 34 percent for ASC services and 29 percent for outpatient hospital services.

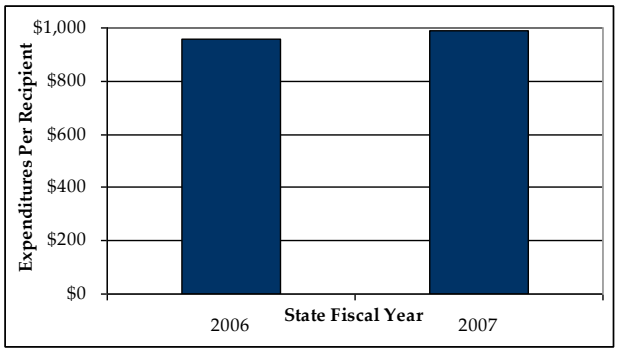
Figure 2: ASC and Outpatient Hospital Expenditures — SFYs 2006-2007



[23] The total expenditures shown in Table 1 may vary from total expenditures in Figure 1 because data was extracted at two different points in time.

ASC expenditures per recipient were $988 in SFY 2007, an increase of three percent from SFY 2006, as shown in the following figure. Wyoming Medicaid payments as a percent of ASC charges were comparable in 2006 and 2007: 33 percent in 2006 and 34 percent in 2007.

Figure 3: ASC Expenditures Per Recipient — SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid pays the lower of the provider's usual and customary charge or the Medicaid fee schedule for services provided in ASCs. Wyoming Medicaid assigns all surgical procedures approved for the ASC setting to a payment group based on the use of resources associated with the procedure. Effective January 1, 2007, Wyoming Medicaid increased ASC rates to 90 percent of Medicare's rates.

Current Issues

Beginning in 2008, CMS is implementing a new Medicare reimbursement methodology to more closely align ASC payments with the outpatient prospective payment system (OPPS). The new methodology is expected to lower payments received by ASCs to take into account the lower cost of providing services in an ASC setting. CMS will implement this change over a four-year transition period. When these changes are implemented, Medicare will no longer maintain its current ASC grouping methodology, which will require Wyoming Medicaid to either consider adopting the same methodology Medicare uses or take over the process of updating the ASC methodology. These updates might make it difficult for Wyoming Medicaid to maintain its ASC reimbursement methodology.

Table A: ASC Services: Expenditures and Recipients by SF

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 1,767,333	1,841	$ 960
2007	1,816,606	1,838	988
Percent Change SFYs 2006-2007	2.8	-0.2	3.0

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

Description

A Comprehensive Outpatient Rehabilitation Facility (CORF) provides coordinated, comprehensive outpatient rehabilitation services at one location. A CORF must provide at least physician supervision and physical therapy and social or psychological services to be certified as a CORF. CORFs may also provide the following services:

- Drugs and biologicals which cannot be self-administered
- Occupational therapy
- Speech therapy
- Orthotics and prosthetics
- Medical supplies and equipment
- Nursing services

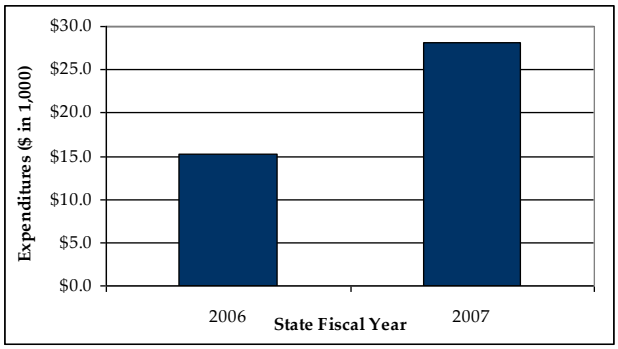
Services provided by CORFs are meant to restore the patient to safe, functional independence; maintenance or general conditioning are not considered appropriate in the CORF setting.

The Gottsche Center in Thermopolis is the only CORF in Wyoming. A CORF in Ft. Collins, Colorado (Center for Neurorehabilitation Services) also serves Wyoming Medicaid recipients.

Expenditures

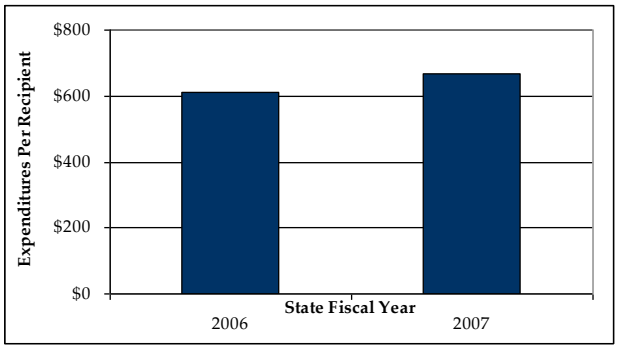
CORF expenditures totaled $28,192 in SFY 2007, an increase of 84 percent from SFY 2006, as shown in Figure 1. Although the percentage change in expenditures is large, it represents a relatively small dollar amount. The large percent increase in expenditures is accompanied by a 68 percent increase in recipients from SFY 2006 to SFY 2007. However, the large percent increase in recipients represents only 17 recipients. CORF expenditures were less than one percent of total Medicaid expenditures in SFY 2007.

Figure 1: CORF Expenditures — SFYs 2006-2007



CORF expenditures per recipient were $669 in SFY 2007, an increase of nine percent from SFY 2006, as shown in the following figure.

Figure 2: CORF Expenditures Per Recipient — SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid reimburses for CORF services at the lower of Medicaid's fee schedule or the provider's usual and customary charge. Wyoming Medicaid has used the UCR methodology since 1994.

Current Issues

There are no current issues for this service area.

Table A: CORF Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B))
2006	$ 15,282	25	$ 611
2007	28,098	42	669
Percent Change SFYs 2006-2007	83.9	68.0	9.4

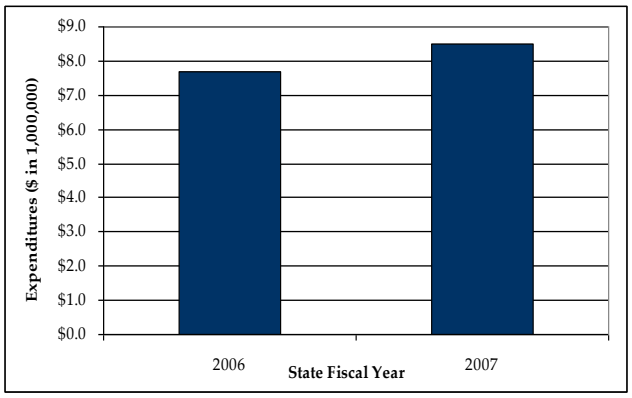
Description

Wyoming Medicaid covers comprehensive dental services for children and young adults under the age of 21. For recipients age 21 and older, Wyoming Medicaid pays for diagnostic and preventive services, basic restorative care and removable prostheses as well as emergency tooth extraction services. Wyoming Medicaid also covers orthodontic services for severe bite problems.

Expenditures

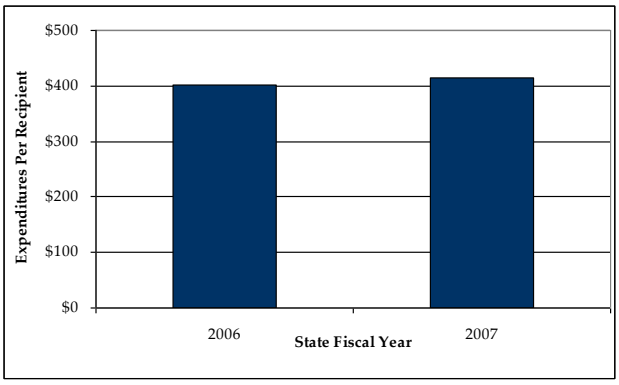
Medicaid dental expenditures totaled $8.51 million in SFY 2007, an 11 percent increase from SFY 2006, as shown in the following figure. Dental expenditures were 2 percent of total Medicaid expenditures for SFY 2007.

Figure 1: Dental Expenditures — SFYs 2006-2007



Dental expenditures per recipient were $415 in SFY 2007, an increase of four percent from SFY 2006, as shown in the following figure.

Figure 2: Dental Expenditures Per Recipient — SFYs 2006-2007



For SFY 2007, the top five procedure codes based on expenditures accounted for $2.47 million (29 percent) of total dental services expenditures, as shown in the following table.

Table 1: Top Five Dental Procedure Codes by Expenditures – SFY 2007

Procedure Code	Procedure Code Description	Expenditures
D2930	Prefabricated Crown	$ 508,535
D8070[24]	Orthodontic Treatment	505,150
D2391	Resin-Based Composite 1 Surface	497,874
D2392	Resin-Based Composite 2 Surfaces	490,953
D1120	Prophylaxis, Child	463,118
Total		**$ 2,465,630**

[24] Wyoming Medicaid pays for limited interceptive and preventive orthodontic services (procedure codes 8050 and 8060). Expenditures for D8070 include expenditures for the State's crippling malocclusion program; this program uses Medicaid funds to provide services to children with severe conditions requiring full orthodontic treatment not covered by Equality Care.

For SFY 2007, the five most frequently performed dental services procedure codes are shown in Table 2.

Table 2: Top Five Dental Procedure Codes by Units of Service – SFY 2007

Procedure Code	Procedure Code Description	Units of Service	Expenditures
D1351	Sealant	15,157	$ 408,179
D0120	Periodic Oral Evaluation	15,006	446,710
D1120	Prophylaxis, Child	13,747	463,118
D1110	Prophylaxis, Adult	6,309	305,561
D7140	Extraction Erupted Tooth	5,961	401,105
Total			**$ 2,024,6673**

The top five providers based on expenditures accounted for slightly over one-third ($ 2.87 million) of total expenditures, as shown in the following table.

Table 3: Top Five Dental Providers by Expenditures – SFY 2007

Provider Name	Expenditures
Provider #1	$ 973,074
Provider #2	511,241
Provider #3	328,056
Provider #4	274,020

The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

On September 1, 2004, Wyoming Medicaid implemented a fee schedule for the most commonly performed dental procedures using the 75th percentile of the average usual and customary fee for each service. Fees for other procedures were similarly calculated. Wyoming Medicaid payments as a percent of billed charges were 75 percent in SFY 2007 as compared to 79 percent in SFY 2006.

Wyoming Medicaid is considering establishing regular annual reimbursement increases for dental services based on the percent change in the Medicare Economic Index. The legislature would need to approve and fund any such annual increases.

Current Issues

Dental shortages exist throughout the United States. There is currently a shortage of dental providers in Wyoming, especially providers who treat Medicaid patients. This shortage is exacerbated by Wyoming's rural and frontier nature. Fourteen Wyoming counties or services areas within a county are designated Dental Health Professional Shortage Areas.[25] The aging of the professional population may also affect the supply of dental services in the future, as half of Wyoming's dentists will reach retirement age within 10 years.[26]

To attempt to address dental access issues, in 2007, the Wyoming Legislature passed a measure establishing an educational loan repayment program for students seeking to pursue a degree in dentistry. Dentists who establish practice in Wyoming for a minimum number of years and accept Medicaid patients may receive repayment for a portion of their dental school tuition.

[25] The Health Resource and Services Administration Health Professional Shortage areas are available by state and county at http://hpsafind.hrsa.gov/HPSASearch.aspx.
[26] Wyoming Department of Health, Office of Health Care Financing, Medicaid Planning and Reporting Meetings, February 5 - 8, 2007, Meeting Notes.

Table A: Dental Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Per Recipient Expenditures (C)=(A/B))
2006	$ 7,698,533	19,211	$ 401
2007	8,511,976	20,532	415
Percent Change SFYs 2006-2007	10.6	6.9	3.5

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

Description

Wyoming Medicaid covers Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) ordered by a physician or other licensed practitioner for home use by Wyoming Medicaid recipients. The purpose of providing DMEPOS is to reduce a patient's physical disability and restore the patient to his or her functional level.

DME is defined as supplies and/or equipment that:

- Withstands repeated use (equipment)
- Serves a medical purpose
- Is generally not useful to a person in the absence of illness or injury
- Is appropriate for use in the home
- Will not be used by any other member of the household

Examples of DME include wheelchairs, crutches, beds and other home medical equipment.

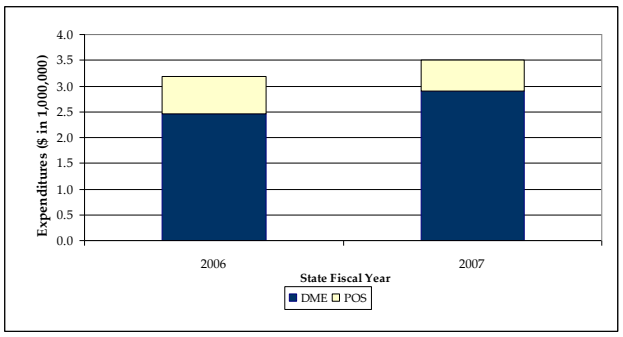
Supplies include diabetic supplies (not to include insulin and insulin syringes billed through the pharmacy program), syringes and needles, urinary care supplies, stocking and elastic supports, respiratory care accessories, supplies and related devices.

Wyoming Medicaid also covers most prosthetic devices, which are items that replace missing parts of the body, and most orthotic appliances, which are items employed for correction or prevention of skeletal deformities.

Expenditures

DMEPOS expenditures totaled $3.51 million in SFY 2007, an increase of 10 percent from SFY 2006, as shown in the following figure. DMEPOS expenditures were one percent of total Medicaid expenditures in SFY 2007.

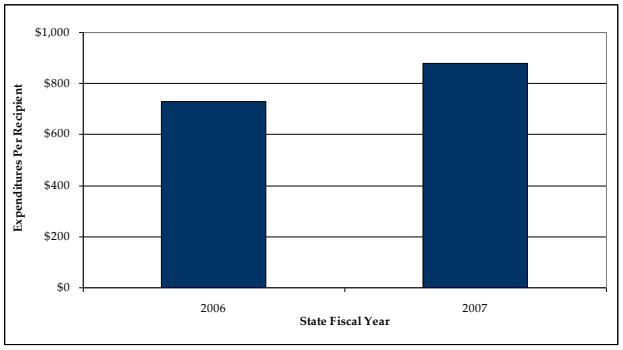
Figure 1: DMEPOS Expenditures — SFYs 2006-2007



Expenditures for DME services totaled $2.91 million in SFY 2007, an increase of 18 percent from SFY 2006, while POS expenditures for SFY 2007 totaled $0.60 million, a decrease of 17 percent from SFY 2006.

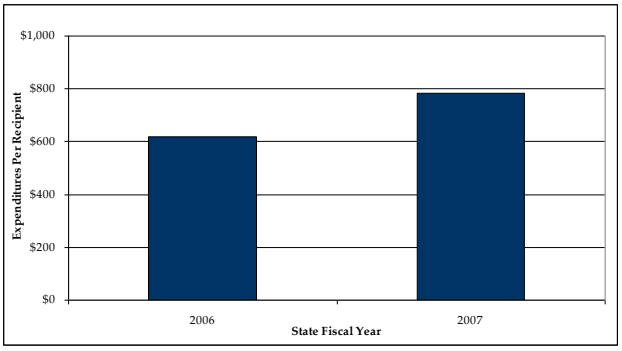
DMEPOS expenditures per recipient increased by 20 percent from $731 per recipient in SFY 2006 to $878 per recipient in SFY 2007, as shown in the figure below.

Figure 2: DMEPOS Expenditures Per Recipient— SFYs 2006-2007



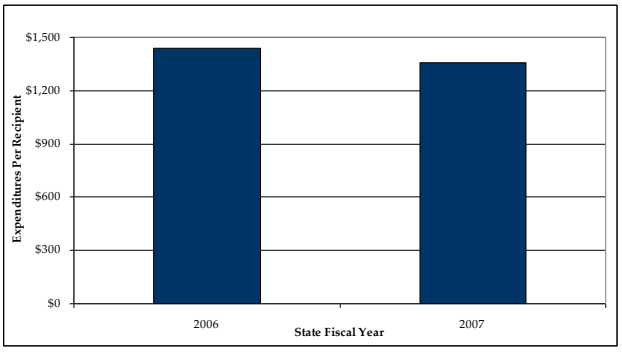
DME expenditures per recipient increased by 27 percent from $617 per recipient in SFY 2006 to $783 per recipient in SFY 2007, as shown in the following figure.

Figure 3: DME Expenditures Per Recipient — SFYs 2006-2007



POS expenditures per recipient decreased by six percent from $1,436 per recipient in SFY 2006 to $1,358 per recipient in SFY 2007, as shown in the following figure.

Figure 4: Prosthetic, Orthotic and Supply Expenditures Per Recipient — SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid pays for DMEPOS using a fee schedule. For each procedure code, providers are paid the lower of usual and customary charges or the Medicaid fee schedule amount. Wyoming Medicaid manually prices certain DME (for example, customized wheelchairs) according to the manufacturer's invoice price, plus a 15 percent add-on, plus shipping and handling. For each new procedure code, Wyoming Medicaid sets rates taking into consideration Medicare rates and other states' rates.

Wyoming Medicaid covers rental of DME, and applies rental payments toward the purchase of DME when the cost of renting equals the cost of purchase, or at the end of 10 months of rental. Wyoming Medicaid automatically purchases low cost items (i.e., less than $150) and caps all rental items, except oxygen concentrators and ventilators, at the purchase price. Wyoming Medicaid also caps all per-day rentals at 100 days and monthly rentals at 10 months. Wyoming Medicaid does not cover routine maintenance and repairs for rental equipment.

Effective October 1, 2005, Wyoming Medicaid pays providers for delivery of equipment to destinations outside of their normal service area (i.e., point of delivery is more than 50 miles roundtrip from the city or provider's place of business) at the State mileage rate of $0.40 per mile.

Current Issues

Wyoming Medicaid updates DMEPOS rates annually according to Medicare updates. Wyoming Medicaid is in the process of reviewing and updating all DMEPOS codes and rates including those codes not covered by Medicare.

Table A: DMEPOS Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 3,190,103	4,366	$ 731
2007	3,507,134	3,995	878
Percent Change SFYs 2006-2007	9.9	-8.5	20.2

END STAGE RENAL DISEASE

Description

Medicare is the primary payer of End Stage Renal Disease (ESRD) services. Medicare ESRD coverage may begin no later than the third month after the month in which the patient begins a course of dialysis treatment. Most recipients of ESRD services are dually eligible for Medicaid and Medicare services. During the 90-day Medicare eligibility determination period, Wyoming Medicaid will reimburse for ESRD services for individuals who meet Medicaid eligibility requirements and will pay for services if Medicare denies eligibility.

Wyoming Medicaid covers all medically necessary services related to renal disease care, including inpatient renal dialysis, and outpatient services related to ESRD treatment. The patient must be enrolled with Medicare and Wyoming Medicaid as an ESRD patient and the hospital or free-standing facility must be certified as an ESRD facility.

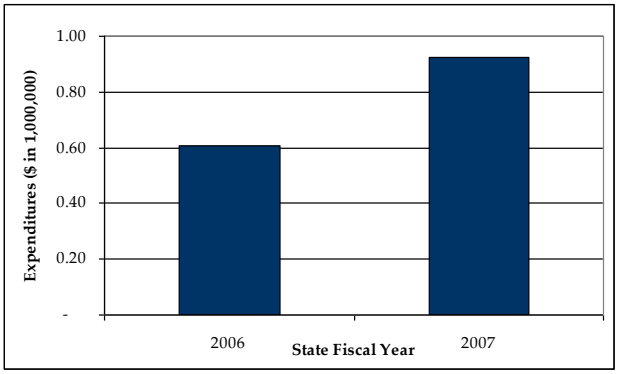
Wyoming Medicaid will also pay for treatment if Medicare denies coverage for a patient on a home dialysis program. Wyoming Medicaid does not cover personal care attendants for this program.

Expenditures

Although most ESRD recipients are dual eligibles, most Medicaid expenditures are for non-dual recipients because Medicare pays for the majority of the ESRD services for dually-eligible individuals.

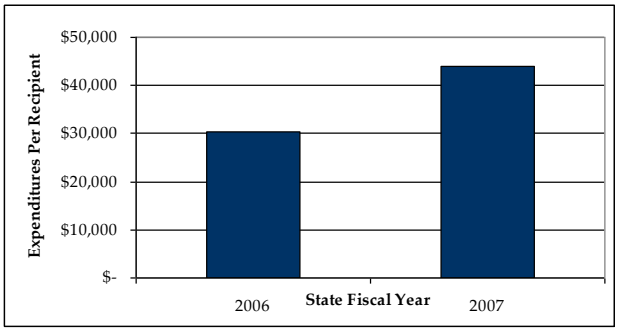
Of the 83 total ESRD recipients in SFY 2007, expenditures for 21 recipients were Medicaid-only funded. ESRD services expenditures for these recipients totaled $.92 million in SFY 2007, an increase of 52 percent from SFY 2006 (representing 20 recipients), as shown in the following figure. ESRD services expenditures for non-dual eligibles were less than one percent of total Medicaid expenditures in SFY 2007.

Figure 1: ESRD Expenditures — SFYs 2006-2007



ESRD expenditures per recipient were $43,955 in SFY 2007, an increase of 45 percent from SFY 2006, as shown in the following figure.

Figure 2: ESRD Expenditures Per Recipient — SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid pays billed charges for dialysis services and pays the lower of the Medicaid fee schedule or the provider's usual and customary charges for other ESRD services.

Current Issues

The State also has a program to pay for ESRD services using only state funds. This State-only funded program originally paid commercial rates for dialysis services, but now reimburses at Medicare rates, which are substantially lower than commercial rates. Wyoming Medicaid may consider paying Medicare rates instead of billed charges to support consistency in payment methodologies between the Medicaid and State-only funded ESRD programs.

Table A: ESRD Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipients Expenditures (C)=(A/B)
2006	$ 608,556	20	$ 30,428
2007	923,060	21	43,955
Percent Change SFYs 2006-2007	51.7	5.0	44.5

FEDERALLY QUALIFIED HEALTH CENTER

Description

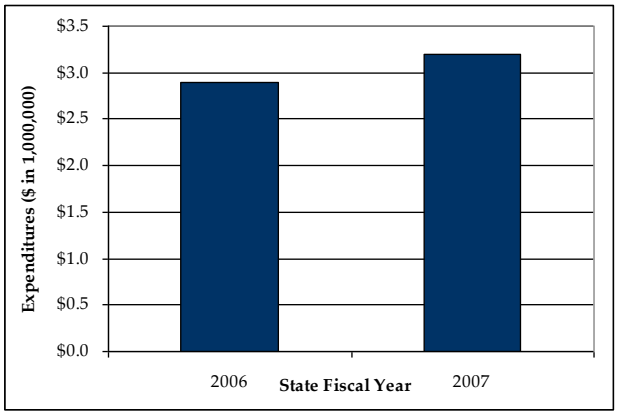
Federally Qualified Health Centers (FQHC) provide preventive primary health services. Wyoming Medicaid reimburses services provided at a FQHC if they are medically necessary and provided by or under the direction of a physician, nurse practitioner, licensed clinical psychologist or licensed clinical social worker.

Medicare designates a facility as an FQHC if it is located in an area designated as a "shortage area". Shortage areas are defined geographic areas designated by the Department of Health and Human Services as having either a shortage of personal health services or a shortage of primary medical care manpower.

Expenditures

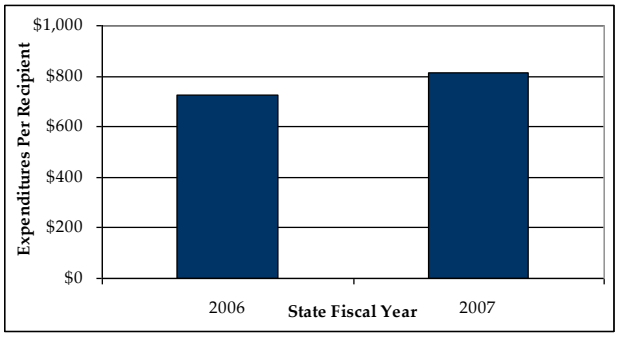
Medicaid FQHC expenditures totaled $3.19 million in SFY 2007, an 11 percent increase from SFY 2006, as shown in the following figure. The increase is attributable to a billing issue for one provider, Community Health Center of Central Wyoming. In SFY 2007, Wyoming Medicaid reimbursed resubmitted claims for this provider that were originally denied in SFY 2006. This resulted in an increase in claims volume and expenditures. Expenditures for FQHC services were about one percent of total Medicaid expenditures in SFY 2007.

Figure 1: FQHC Expenditures — SFYs 2006-2007



FQHC expenditures per recipient were $812 in SFY 2007, an increase of 12 percent from SFY 2006, as shown in the following figure.

Figure 2: FQHC Expenditures Per Recipient — SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid reimburses FQHCs according to a prospective payment system (PPS) as required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The PPS is based on 100 percent of a facility's average costs during SFY 1999 and SFY 2000. FQHCs are paid the prospective rate, without a comparison of actual charges to the fee schedule amount. The rates are updated annually for inflation based on the Medicare Economic Index (MEI).

Current Issues

States are required to reevaluate FQHC rates should an FQHC change its scope of services. Because the PPS has now been in effect for more than five years, Wyoming Medicaid may consider conducting an analysis of current FQHC cost report data to assess the need for adjustments to rates to reflect changes, for example, in the scope of services provided by each FQHC and how these changes affect the costs of services.

Table A: FQHC Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 2,888,469	3,987	$ 724
2007	3,191,251	3,929	812
Percent Change SFYs 2006-2007	10.5	-1.5	12.1

HOME HEALTH

Description

Wyoming Medicaid covers home health services if the Medicaid recipient is not an inpatient of a hospital or nursing care facility. Covered services must be:

- Intermittent
- Three or fewer visits a day for home health aide and/or skilled nursing services, where each visit does not last more than four hours
- Medically necessary and ordered by a physician
- Documented in a signed and dated Plan of Treatment that is reviewed and revised as medically necessary by the attending physician, at least once every 60 days

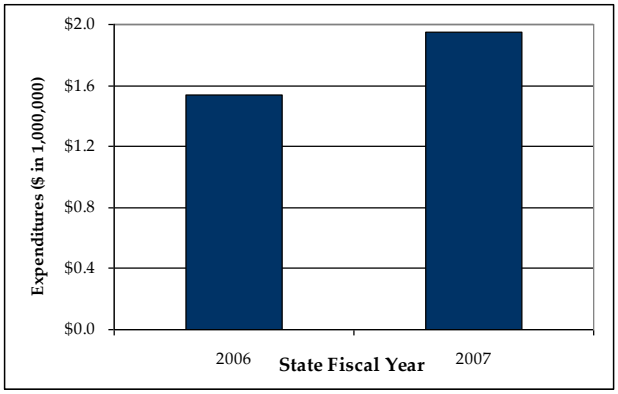
Covered services include:

- Skilled nursing services
- Home health aide services supervised by a qualified professional
- Physical therapy services provided by a qualified, licensed physical therapist
- Speech therapy provided by a qualified therapist
- Occupational therapy provided by a qualified, registered or certified therapist
- Medical social services provided by a qualified, licensed MSW or BSW-prepared person supervised by an MSW
- Wyoming Medicaid does not cover homemaker services, respite care, meals on wheels or services that are inappropriate or not cost-effective when provided in the home setting.

Expenditures

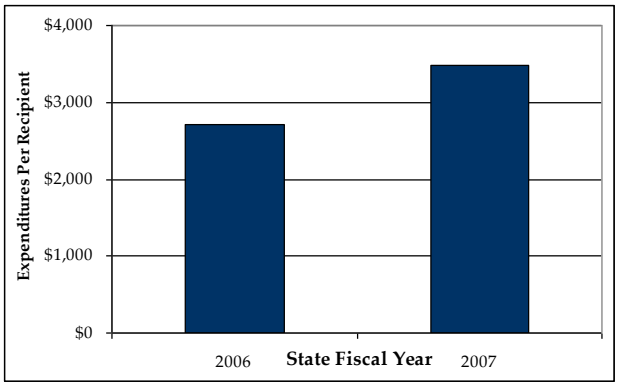
Expenditures for home health services totaled $1.95 million in SFY 2007, an increase of 27 percent from SFY 2006, as shown in the following figure. Home health expenditures were less than one percent of total Medicaid expenditures in SFY 2007.

Figure 1: Home Health Expenditures — SFYs 2006-2007



Home health expenditures per recipient were $3,481 in SFY 2007, an increase of 28 percent from SFY 2006, as shown in the following figure. The increase in expenditures per recipient is likely due to the increase in reimbursement rates from SFY 2006 to 2007 as described on the following page.

Figure 2: Home Health Expenditures Per Recipient — SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid reimburses home health providers on a per visit basis. Effective July 1, 2006, home health providers received a Medicaid rate increase of 30 percent from $64 per visit to $84 per visit for skilled nursing, physical therapy, speech

therapy, occupational therapy, home health and medical social workers. This was the first rate increase since 1989, when the rates were originally set.

Current Issues

As spending and demand for long-term care services continue to increase, an increasing number of consumers are seeking services in their homes and communities. The demand for home health services is likely to increase as well. Department staff report that home health agencies are currently experiencing difficulty hiring and retaining needed staff. One factor contributing to the workforce shortages is competition for staff with Wyoming's energy extraction industries.

Some home health recipients also have mental health diagnoses. These consumers require staff with specialized skills. Department staff report that mental health diagnoses are the third most frequent diagnosis for home health recipients. The State is currently exploring ways to recruit Community Mental Health Center (CMHC) staff as case managers for these recipients.

Table A: Home Health Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 1,534,561	566	$ 2,711
2007	1,949,500	560	3,481
Percent Change SFYs 2006-2007	27.0	-1.1	28.4

Description

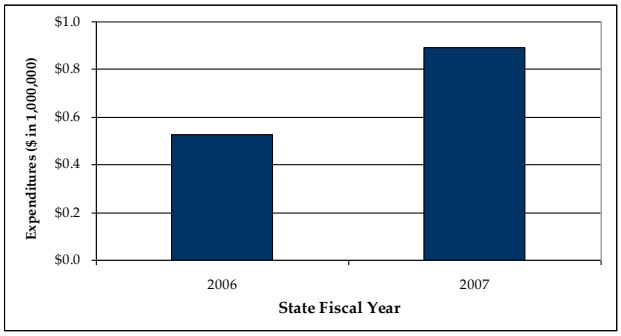
Hospice care is an interdisciplinary approach to caring for the psychological, social, spiritual and physical needs of dying patients. Wyoming Medicaid reimburses hospice care for Medicaid recipients if a physician certifies that the recipient is terminally ill and the recipient elects to receive hospice care.

Wyoming Medicaid reimburses hospice, independent physician services and HCBS services provided to the recipient in a hospice setting. Covered services include routine and continuous home care, inpatient respite care and general inpatient care. Inpatient services are provided during critical periods for patients who need a high level of care.

Expenditures

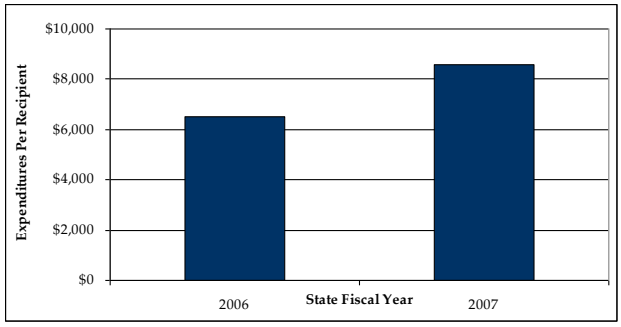
Hospice care expenditures totaled $0.89 million in SFY 2007, an increase of 70 percent from SFY 2006, as shown in the following figure. Although the percent increase is substantial, it represents a relatively small dollar amount and an increase of only 20 recipients from SFY 2006. Hospice expenditures were less than one percent of total Medicaid expenditures in SFY 2007.

Figure 1: Hospice Expenditures — SFYs 2006-2007



Hospice expenditures per recipient were $8,594 in SFY 2007, an increase of 32 percent from SFY 2006, as shown in the following figure.

Figure 2: Hospice Expenditures Per Recipient— SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid reimburses hospice providers according to Medicare rates, which CMS updates every year in October.

Most hospice services are provided at home. In situations where a nursing facility resident elects to receive hospice care, the resident may receive hospice benefits if the hospice and the nursing facility have a written agreement that the hospice will take responsibility for management of the individual's hospice care, and the nursing facility will provide room and board. In these instances, Wyoming Medicaid will pay the hospice 95 percent of the room and board portion of the nursing facility's per-diem rate, and the hospice will reimburse the nursing facility according to their agreement.

Likewise, for inpatient respite care and general inpatient care, the recipient may receive inpatient hospice services if the hospice provider and the hospital have a written agreement. Wyoming Medicaid reimburses the hospice provider; the hospice provider reimburses the hospital according to their agreement.

Current Issues

There are no current issues for this service area.

Table A: Hospice Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 527,147	81	$ 6,508
2007	893,736	104	8,594
Percent Change SFY to 2006-2007	69.5	28.4	32.1

Description

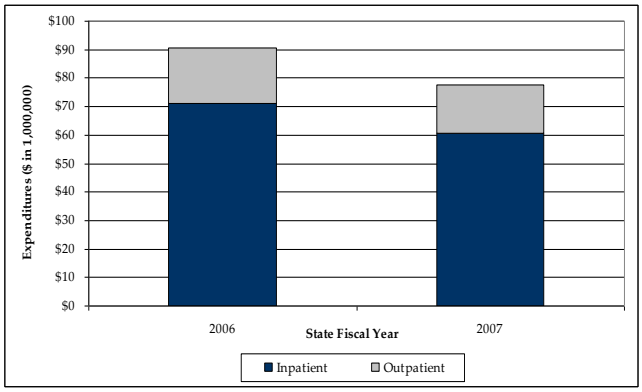
Wyoming Medicaid covers inpatient hospital services, with the following exceptions: alcohol and chemical rehabilitation services; cosmetic surgery and experimental services. In addition, Wyoming Medicaid covers only those surgical procedures that are medically necessary. Wyoming Medicaid may not cover a surgery if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the patient.

Wyoming Medicaid also covers outpatient hospital services. Outpatient hospital departments provide outpatient hospital services including emergency room, surgery, laboratory, radiology and other testing services. Wyoming Medicaid limits visits to hospital outpatient departments, physician offices and optometrist offices to a maximum of 12 per calendar year for recipients over the age of 21. Family planning visits, Health Check (Early Periodic Screening, Diagnosis and Treatment) services and emergency services for all recipients are exempt from the 12-visit limit.

Expenditures

Medicaid hospital expenditures totaled $77.5 million (all discussion of expenditures, unless otherwise noted, include Qualified Rate Adjustment payments, which are described below) in SFY 2007, a 14.5 percent decrease from SFY 2006, as shown in the following figure. Seventy-eight percent ($60.5 million) of the total hospital expenditures in SFY 2007 represent inpatient hospital payments. Hospital expenditures were 21 percent of total Medicaid expenditures in SFY 2007.

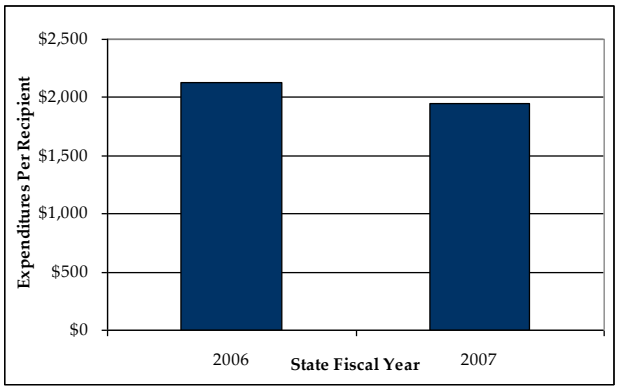
Figure 1: Total Hospital Expenditures — SFYs 2006-2007



Inpatient hospital expenditures totaled $60.5 million in SFY 2007, a decrease of 15 percent from SFY 2006; outpatient hospital expenditures for SFY 2007 totaled $16.9 million, a decrease of 12.7 percent from SFY 2006.

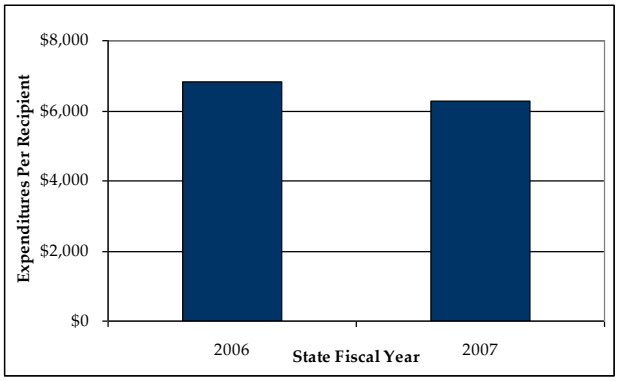
Hospital expenditures per recipient decreased by 8.6 percent from $2,129 per recipient in SFY 2006 to $1,947 per recipient in SFY 2007, as shown in the following figure.

Figure 2: Total Hospital Expenditures Per Recipient — SFYs 2006-2007



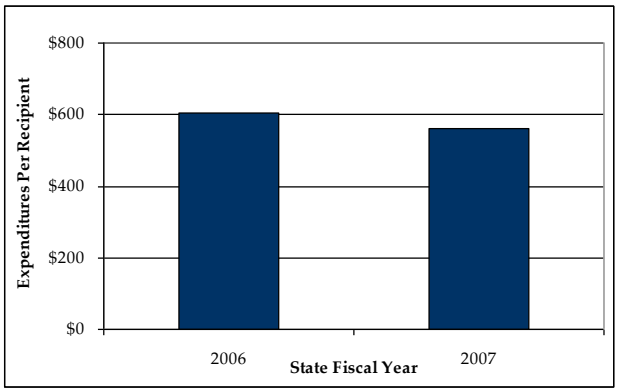
Inpatient hospital expenditures per recipient decreased by 8 percent from $6,812 per recipient in SFY 2006 to $6,270 per recipient in SFY 2007, as shown in the following figure.

Figure 3: Inpatient Hospital Expenditures Per Recipient — SFYs 2006-2007



Outpatient hospital expenditures per recipient decreased by 7 percent from $604 per recipient in SFY 2006 to $562 per recipient in SFY 2007, as shown in the following figure.

Figure 4: Outpatient Hospital Expenditures Per Recipient — SFYs 2006-2007



As illustrated in the expenditure figures above, both inpatient and outpatient hospital expenditures decreased from SFY 2006 to SFY 2007, and the number of recipients and eligibles for hospital services also decreased over these two years.

Reimbursement Methodology

Wyoming Medicaid reimburses inpatient and outpatient hospital services differently, and the following sections describe the methodology for each in further detail.

Inpatient Hospital

Wyoming Medicaid pays for inpatient hospital services using three different approaches, depending upon the type of service:

- Level of care prospective rate per discharge – Used to pay for general inpatient acute care services
- Prospective negotiated rate -- Used to pay for specialty extended psychiatric and specialty rehabilitation services
- Payment of 55 percent of billed charges – Used to pay for transplant services

Level of Care Methodology

In the level of care system, Wyoming Medicaid pays a prospective payment amount per discharge. Each discharge is classified into a level of care based on the diagnosis, procedures and revenue codes that hospitals report on the inpatient claim.

Some per discharge rates are calculated based on the costs of the level of care discharges of all hospitals; others are set based on each hospital's own costs. Most out-of-state hospitals are paid using this same approach; those hospitals that provide a relatively low volume of services are paid a rate that is equal to the statewide average payment rate for the level of care. Some out-of-state hospitals also receive additional payments for medical education.

There are nine levels of care:

- Maternity (medical)
- Maternity (surgical)
- Intensive care, critical care and burn units
- Surgery
- Psychiatric care
- Rehabilitation
- Newborn
- Newborn readmission
- Routine care

Wyoming Medicaid pays additional amounts for each discharge if the costs of that discharge exceed three times (two times for children's hospitals) the

level of care payment, known as the "threshold". The additional payment amount is 75 percent of the costs that exceed the threshold.

Wyoming Medicaid inflates the level of care rates annually by Medicare's inpatient hospital prospective payment system inflation index. In SFYs 2007 and 2008, Wyoming Medicaid updated the rates by 3.4 and 3.2 percent, respectively. Wyoming Medicaid periodically recalculates rates using more recent cost and claims data.

Disproportionate Share Hospital Payments

Wyoming Medicaid makes additional payments to hospitals that serve a disproportionate number of low-income patients. These disproportionate share hospital (DSH) payments are required by federal law.

Wyoming Medicaid determines the amount of DSH payment to each qualifying hospital using final settled Medicare cost reports. Because of the delay in final settlement by Medicare auditors (at least two years), Wyoming Medicaid cannot determine DSH payments until several years after the additional costs have been incurred by hospitals. This delay has made it difficult for the Department to access enhanced federal funding. Under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), extremely low-DSH states will receive a 16 percent increase for FFYs 2004 through 2008.[27] Wyoming Medicaid was not able to qualify for this low-DSH state status due to its two-year lag in DSH payment calculations.

Wyoming's federal DSH allotment after FFY 2004 will increase only after the DSH allotment calculated using the pre-FFY 2004 annual update methodology equals Wyoming's FFY 2004 allotment ($117,740). After that, Wyoming's DSH allotment will increase annually using the consumer price index.

[27] Extremely low-DSH states are states whose DSH payments accounted for less than 3 percent of total medical assistance expenditures in FFY 2000. Wyoming's FFY 2004 DSH payments were $105,108.

Qualified Rate Adjustment Payments

Wyoming Medicaid provides supplemental payments to non-state government owned or operated providers whose Medicaid payments are below 100 percent of estimated costs with Qualified Rate Adjustment Payments (QRA). Wyoming Medicaid paid 20 hospitals a total $5.8 million in inpatient hospital QRA payments (federal and state share) in SFY 2007. Qualifying hospitals provide the state share of the QRA payment, and the Department distributes the corresponding federal matching Medicaid funds to these hospitals.

Outpatient Hospital

Wyoming Medicaid implemented an Ambulatory Payment Classification (APC)-based bundled outpatient hospital payment system on October 1, 2005 for all hospitals. The APC system groups services for payment the same way as Medicare does and uses many of Medicare's APC payment policies, adjusted to reflect the Wyoming Medicaid population. Wyoming Medicaid pays for the following services under APCs:

- Significant outpatient procedures[28]
- Ancillary services
- Drugs
- Selected laboratory services
- Radiology
- Selected durable medical equipment, prosthetics and orthotics
- Selected vaccines and immunization services that are not paid for under Medicaid's physician fee schedule

Prior to October 1, 2005, Wyoming Medicaid paid for outpatient hospital services using a fee schedule based on the type of services, and paid the lower of charges or the flat rate per procedure or revenue code for all services except surgery. The fee schedule for surgery services was based on the ASC methodology – a single payment was established for

[28] A procedure provided to a Medicaid enrollee that constitutes the primary reason for the visit to the healthcare professional.

each "bundle" of outpatient hospital surgery services. Wyoming Medicaid did not update rates for services, with the exception of laboratory services. Wyoming Medicaid excluded critical access hospitals from this system on October 1, 2001, paying these hospitals at 70 percent of billed charges.

The goals of Wyoming Medicaid's APC-based system are to promote equity and consistency of outpatient hospital payments among provider types, predictability of outpatient hospital payments and access to quality care. Specific objectives of the project are aligned with Wyoming Medicaid's overall strategic direction to improve the efficiency and effectiveness of operations relating to the provision of customer services such as health care to Medicaid clients.

APC-Based Methodology

The APC methodology is designed to pay hospitals based on the resources used to provide a service. For each unit of service (generally, either the procedure or visit), payment equals Medicare's relative weight (which measures the resources needed to provide a specific unit of services in relation to all services) for the APC, multiplied by a conversion factor (a standard dollar amount used to translate these relative weights into payment). When multiple units of services and different services are provided, payments are subject to discounting and unit limitations.

Wyoming Medicaid uses three conversion factors that vary by hospital type: children's, general acute and critical access hospitals.

As illustrated in Table 1, Wyoming Medicaid excludes select services from the APC methodology and pays for them using a separate Wyoming Medicaid fee schedule.

Wyoming Medicaid annually updates the APC relative weights using the most current Medicare relative weights and also evaluates updates to the conversion factors annually.

Table 1: Services Excluded from APC Methodology and Paid by Fee Schedule

Service	Fee Schedule
Selected DME	DME fee schedule
Selected vaccines and immunizations, selected radiology and mammography screening and diagnostic mammographies and Therapies	Physician fee schedule
Laboratory services	Laboratory fee schedule
Corneal tissue services, new medical devices covered under Medicare's transitional pass-through payments, and dental and bone marrow transplant services	Percent of charges

Qualified Rate Adjustment Payments

Medicaid also supplements qualified outpatient hospital providers with QRA payments. Wyoming Medicaid paid 16 hospitals a total of $4.9 million in outpatient QRA payments in SFY 2007 (federal and state share). Qualifying hospitals provide the state share of the QRA payment, and the State distributes the corresponding federal matching Medicaid funds to the participating hospitals.

Current Issues[29]

The following sections summarize estimated cost coverage for all hospital services and for inpatient and outpatient services separately.

- Overall estimated cost coverage for inpatient and outpatient hospital services with and without QRA payments is 89 and 83 percent for SFY 2007 (all providers, all services), respectively.[30]

[29] Findings exclude DSH payments and include the federal share of QRA payments unless otherwise indicated.

[30] Estimated cost coverage is an estimate of the percentage of a provider's costs that are covered by Medicaid payments. We have estimated inpatient hospital costs by applying hospital room and board cost per diems and ancillary cost-to-charge ratios (calculated from Medicare cost reports) to routine and ancillary

- Estimated SFY 2007 cost coverage for in-state inpatient services is higher than that for in-state outpatient hospital services – an estimated 87 percent cost coverage (81 percent excluding QRA payments) as compared to 77 percent (64 percent excluding QRA payments), respectively.

Inpatient Hospital

This section describes cost coverage for Medicaid inpatient hospital services (both level of care and specialty services) paid in SFY 2006 and SFY 2007.

- From SFY 2006 to SFY 2007, estimated inpatient cost coverage for level of care services decreased from 95 percent to 92 percent. Excluding QRA payments, estimated inpatient cost coverage for level of care services decreased from 92 to 87 percent.
- In-state hospitals provide more of the maternity and newborn care than all out-of-state hospitals. Sixty-two percent of in-state hospital discharges are for maternity and newborn care as compared to 39 percent of out-of-state discharges. In-state hospitals also provide more intensive care unit and surgery care services than all out-of-state hospitals. Ten percent of in-state hospital discharges are intensive care unit and surgery discharges as compared to three percent of out-of-state discharges.
- When compared to in-state hospitals, out-of-state hospitals have a higher average cost per claim and average payment per claim across all levels of care.
- The majority of payments are made under the level of care payment methodology: only 4 percent of payments are made through other payment approaches. Estimated cost coverage for non-level of care inpatient services was approximately 119 percent in SFY 2007 as compared to 87 percent for level of care services (excluding QRA payments). The following table shows inpatient cost coverage for SFYs 2006 and 2007.

Table 2: Estimated Inpatient Hospital Cost Coverage, by SFY[31]

SFY	In-State Hospitals		Out-of-State Hospitals	Total	
	Without QRA	With QRA		Without QRA	With QRA
2006	85	90	106	91	94
2007	81	87	108	88	93

- By level of care, estimated cost coverage ranged from 73 to 136 percent in SFY 2007 (excluding QRA payments). Estimated cost coverage for normal newborn level of care services (136 percent), readmit newborn level of care services (122 percent) and psychiatric level of care services (99 percent) was substantially higher than for all level of care services combined (87 percent before QRA payments). Estimated cost coverage for maternity/medical level of care services (73 percent), maternity/surgical level of care services (77 percent) and routine care level of care services (77 percent) is substantially lower than for all level of care services. Exhibit 1 provides additional detail.
- Estimated cost coverage for psychiatric level of care services and extended psychiatric services combined (110 percent) exceeds that for all inpatient services combined (88 percent before QRA payments). Wyoming Medicaid paid 94 percent of payments for inpatient psychiatric services to five providers and 77 percent of these payments to a single provider that had estimated cost coverage of 130 percent.
- Inpatient claims with a mental health or substance abuse primary diagnosis make up approximately 6 percent of the total inpatient

Medicaid services, respectively. We have estimated outpatient hospital costs by applying ancillary cost-to-charge ratios (calculated from Medicare cost reports) to outpatient hospital department-specific charges.

[31] QRA payments are supplemental reimbursement for all services.

hospital payments (excluding QRA) for SFY 2007.[32]

- In SFY 2007, claims with emergency room services represented approximately $13.7 million (23 percent) of total inpatient expenditures ($58.6 million) for all hospitals. The top five diagnosis codes associated with claims with emergency room services, by total payments, are listed in the following table.[33] The top five diagnosis codes identified by the total number of claims are the same as those identified using total payments, except that Acute Bronchitis, (466.19) replaces unspecified septicemia (038.9).

Table 3: Top Five Diagnosis Codes for Emergency Room Inpatient Claims, by Payment

Primary Diagnosis Code	Number of Claims	Claim Payments
486 (Pneumonia, organism specified)	143	$ 574,366
038.9 (Unspecified septicemia)	21	304,072
276.51 (Volume depletion, dehydration)	85	257,231
466.11 (Acute bronchitis due to respiratory syncytial virus)	65	235,714
493.92 (Asthma, unspecified)	59	$ 208,920

- The cost-to-charge ratios Wyoming Medicaid uses to determine outlier level of care payments do not reflect Wyoming hospitals' current charge and cost experience (Wyoming uses cost-to-charge ratios calculated using 1994 cost report data). A review of more current cost report data indicates that cost-to-charge ratios have generally decreased over time. Therefore, Wyoming Medicaid may be reimbursing a greater percentage of costs under its outlier policy than it originally intended.
- Wyoming Medicaid is in the process of considering options to rebase its inpatient prospective payment system.

[32] Mental health and substance abuse claims are those with a primary diagnosis code in one of the following ranges of ICD-9 codes: 293 - 302.9 and 306 - 313.9 for mental health and 291 - 292.9 and 303 - 305.9 for substance abuse. Total inpatient hospital payments (excluding QRA) equal the sum of payments for all providers (in-state, out-of-state, participating and non-participating).

[33] Inpatient claims with emergency room services represent claims with a revenue code of 045X on any line of the claim. The payments equal the payment amount for the whole claim with the emergency room service, not just the line level payment.

Exhibit 1: Estimated Cost Coverage (SFY 2007), by Level of Care and Specialty Service[34]

Type of Service		Claims	Payments[35]	Estimated Cost Coverage (Percent)
Level of Care Services	Maternity/Surgical	1,070	$ 4,827,942	77
	Maternity/Medical	2,470	6,100,428	73
	ICU/CCU/Burn Care	638	12,624,293	85
	Surgery Care	737	7,496,004	80
	Psychiatric Services	379	1,437,033	99
	Rehabilitation Services	0	0	0
	Normal Newborn Care	3,188	11,108,112	136
	Readmit Newborn Care	78	160,243	122
	Routine Care	2,525	9,599,587	77
	Subtotal	*11,085*	*53,353,642*	*87*
Specialty Services	Bone Marrow Transplant	1	52,563	95
	Extended Psychiatric Services	315	2,082,979	119
	Specialty Rehabilitation Services	5	127,626	157
	Liver Transplants	1	68,246	95
	Subtotal	*322*	*2,331,414*	*119*
Subtotal (before QRA payments)		***11,407***	***55,685,055***	***88***
QRA Payments (Federal share)			2,897,680	
Total (after QRA payments)			**$ 58,582,735**	**93**

[34] Total payments shown in this exhibit are slightly lower than total inpatient hospital expenditures reported at the beginning of this section because this exhibit provides information for participating providers only. Appendix A provides the definition of participating providers.
[35] Due to rounding, the sum of the expenditures for level of care and specialty services will vary from the total listed in Exhibit 1.

Outpatient Hospital[36]

This section summarizes cost coverage for Medicaid outpatient hospital services paid in SFY 2006 and SFY 2007.

- Cost coverage for outpatient services (in-state providers with QRA payments) increased slightly from an estimated 76 percent in SFY 2006 to 77 percent in SFY 2007 as shown in the following table.

Table 4: Estimated Cost Coverage of Outpatient Hospital Services, for In-State Providers by SFY

State Fiscal Year	Estimated Cost Coverage	
	Without QRA	With QRA
2006	63	76
2007	64	77

- Outpatient claims with a mental health or substance abuse primary diagnosis represent approximately 1.3 percent of the total outpatient hospital payments (excluding QRA) for SFY 2007.[37]
- In SFY 2007, outpatient claims with emergency room services contributed approximately $5.2 million to total outpatient expenditures of $14.7 million. The top five diagnosis codes associated with claims with emergency room services, by payment level, are listed in the following table. The top five diagnosis codes identified by the total number of claims are the same as those identified using total payments, except that Acute Pharyngitis (462) replaces Other Symptoms Involving Abdomen and Pelvis and Fever (780.6) follows Acute Pharyngitis. Contusion of Face, Scalp and Neck Except Eyes (920) is not in the top five diagnosis codes identified by the number of claims.

Table 5: Top Five Diagnosis Codes for Outpatient Emergency Room Claims, by Payments

Primary Diagnosis Code	Number of Claims	Claim Payments
382.9 (Unspecified otitis media)	2,147	$ 201,806
465.9 (Acute upper respiratory infections of unspecified site)	1,711	175,601
789.00 (Other symptoms involving abdomen and pelvis)	447	98,834
558.9 (Other and unspecified noninfectious gastroenteritis and colitis)	638	92,326
920 (Contusion of face, scalp, and neck except eye(s))	533	$ 88,865

[36] Analyses described in this section exclude DSH payments and include the federal share of QRA payments unless otherwise indicated. Disproportionate share hospital payments provide extra reimbursement to qualifying providers to pay for low-income patients, within the federal allotment.

[37] Mental health and substance abuse claims are those with primary diagnosis codes 293 - 302.9 and 306 - 313.9 for mental health and 291 - 292.9 and 303 - 305.9 for substance abuse. Total outpatient hospital payments (excluding QRA) equal the sum of payments for all providers.

Table A: Total Hospital Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	QRA Payments (Federal Share)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 90,581,530		42,538	$ 2,129
2007	77,449,970		39,779	1,947
Percent Change SFYs 2006-2007	-14.5		-6.5	-8.6

Table B: Inpatient Hospital Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	QRA Payments (Federal Share) (B)	Number of Recipients (C)	Per Recipient Expenditures (D)=(A+B/C)
2006	$ 68,786,442	$ 2,429,260	10,455	$ 6,812
2007	57,636,819	2,897,680	9,654	6,270
Percent Change SFYs 2006-2007	-15.0		-7.7	-8.0

Table C: Outpatient Hospital Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	QRA Payments (Federal Share) (B)	Number of Recipients (C)	Per Recipient Expenditures (D)=(A+B/C)
2006	$ 16,176,467	$ 3,189,361	32,083	$ 604
2007	14,483,373	2,432,098	30,125	562
Percent Change SFYs 2006-2007	-12.0		-6.1	-7.0

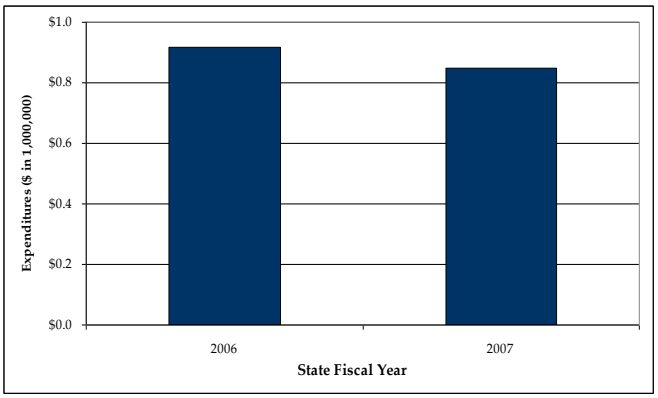
Description

Wyoming Medicaid covers professional and technical laboratory services ordered by a practitioner that are directly related to the diagnosis and treatment of the patient as specified in the treatment plan developed by the ordering practitioner.

Expenditures[38]

Laboratory expenditures totaled $0.85 million in SFY 2007, a decrease of seven percent from SFY 2006, as shown in the following figure. Laboratory expenditures were less than one percent of total Medicaid expenditures in SFY 2007.

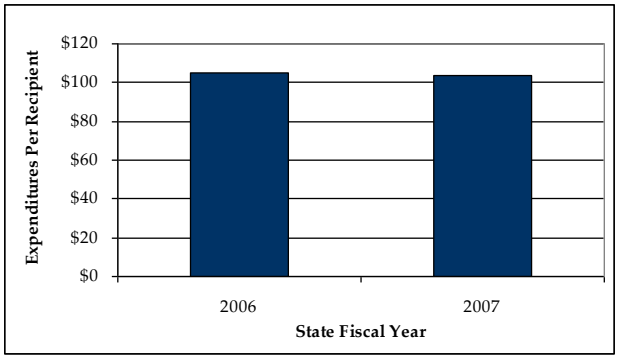
Figure 1: Laboratory Expenditures — SFYs 2006-2007



In SFY 2007, 12 percent of expenditures represented genetic testing services and 1 percent represented EPSDT services.[39]

Laboratory expenditures per recipient decreased slightly by one percent from $105 per recipient in SFY 2006 to $104 per recipient in SFY 2007, as shown in Figure 2.

Figure 2: Laboratory Expenditures Per Recipient— SFYs 2006-2007



The table following this narrative provides detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Reimbursement Methodology

Wyoming Medicaid pays the lower of the Medicaid fee schedule or the provider's usual and customary charges for laboratory services. Wyoming Medicaid increased fees in January 2005, and is analyzing and updating all laboratory procedure codes for SFY 2008 based on 90 percent of Medicare's fees.

Current Issues

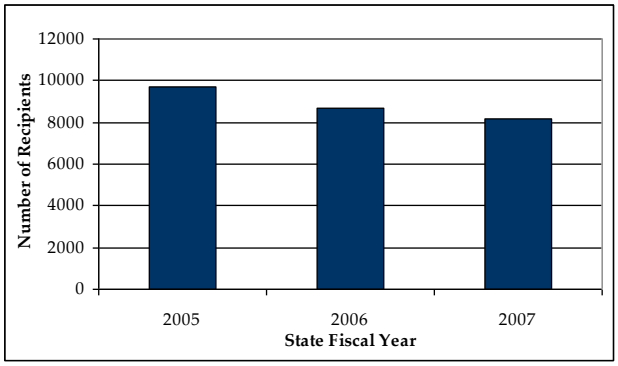
Providers throughout the State have expressed that malpractice concerns have caused an increase in unnecessary diagnostic testing.

As illustrated in the following figure, the number of Medicaid recipients receiving laboratory services decreased by 16 percent from SFY 2005 to SFY 2007. The decrease for laboratory recipients is higher than the total decrease in Medicaid recipients (three percent) in the same time period.

[38] Expenditure data includes expenditures only for those services performed by a Clinical Medical Laboratory, as opposed to a physician's office.

[39] We defined EPSDT services using diagnosis code V.20.2. We defined genetic testing CPT codes as 36415, 88291, 99214, 99244, per a November 9, 2007 email correspondences from Angela DeBerry at the Department of Health.

Figure 3: Laboratory Recipients — SFYs 2005-2007



Laboratory expenditures per recipient, however, increased by six percent from SFY 2005 to SFY 2007, as shown in the following figure. This could be due to any number of factors, such as variation in recipient case mix, age or other factors, between SFY 2006 and SFY 2007.

Figure 4: Laboratory Expenditures per Recipient — SFYs 2005-2007

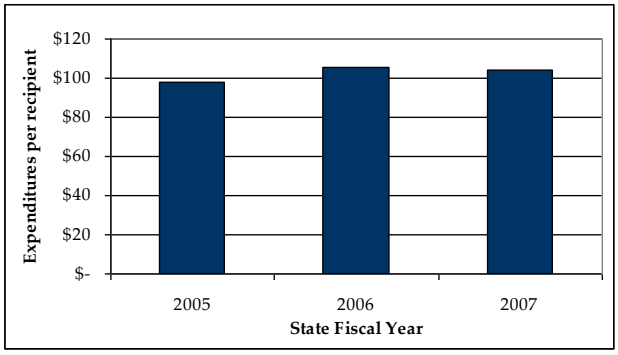


Table A: Laboratory Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 916,968	8,710	$ 105
2007	847,503	8,154	104
Percent Change SFYs 2006-2007	-7.6	-6.4	-1.3

Long-Term Care Description

Wyoming Medicaid covers long-term care services through a long-term care home- and community-based services (LTC/HCBS) waiver, an assisted living facility (ALF) waiver and through reimbursement of nursing facility services.

Wyoming also provides long-term care services to individuals with developmental disabilities. We discuss these services in the Waiver Habilitation section of the Annual Report.

This section begins with a description of overall long-term care expenditures and issues, and then provides information specific to the LTC/HCBS waiver program, ALF waiver and nursing facility services.

Long-Term Care Expenditures

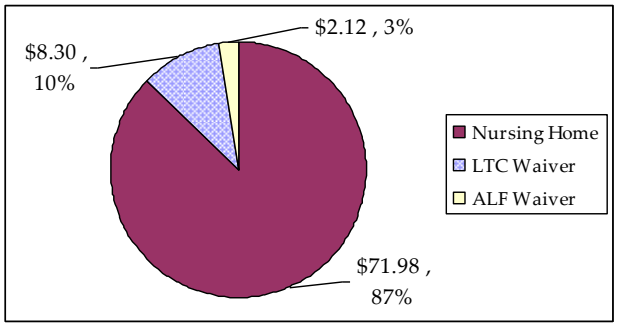
Long-term care expenditures totaled $82.4 million in SFY 2007, a decrease of three percent from $84.9 million in SFY 2006.[40] In SFY 2007, 87 percent of long-term care expenditures was spent on nursing facility services, 10 percent was spent on LTC/HCBS waiver services and the remainder (three percent) was spent on ALF waiver services, as shown in Figure 1. Long-term care expenditures were 23 percent of total Medicaid expenditures in SFY 2007.

Expenditures per recipient also vary between the waivers and individuals receiving nursing facility services in SFY 2007, and are discussed in detail in the subsections that follow

Since nursing facility expenditures account for most long-term care expenditures, the decrease in total long-term care expenditures can be attributed to the decrease in nursing facility expenditures from SFY 2006 to SFY 2007. Expenditures for LTC/HCBS recipients also decreased, while expenditures for ALF waiver recipients increased.

[40] Totals exclude ICF/MR (State School) expenditure data, and include waiver service expenditures received by long-term care waiver and assisted living facility waiver recipients.

Figure 1: Expenditures in Millions as a Percent of Total Long-Term Care Expenditures — SFY 2007



The subsections that follow provide more detail on the change in the past year in the number of recipients served by each waiver and nursing facilities, and the expenditures for these recipients. The tables following each subsection provide detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

Current Issues

The population in Wyoming is aging, creating a demand for more and varied long-term care services provided in both institutions and in the community. In 2004, the median age of Wyoming's population was two years older than the median age for the nation.[41] Additionally, Wyoming currently has a high proportion of baby boomers between the ages of 45 and 59, who will be aging into retirement within several years. Projections indicate that the 65 and older age group will grow at an annual rate of three percent and reach 15 percent by 2014.[42]

At the same time, the aging of the baby boom generation will affect the labor supply, as workers retire and are replaced by fewer younger workers. There will be fewer providers and staff available to provide long-term care services to the aging population. Young workers in Wyoming, including

[41] State of Wyoming, Department of Administration and Information, Economic Analysis Division, "10 Year Outlook: Wyoming Economic and Demographic Forecast 2005 to 2014" (October 2005).
[42] Ibid.

those who migrate to the State, are often drawn to jobs in the energy and mining industries, which have experienced growth in recent years. For example, the mining industry accounted for 37 percent of new jobs in Wyoming in 2004.

These trends will continue to affect the provision of long-term care services in Wyoming in the future.

Long-Term Care Home- and Community-Based Services Waiver Description

Wyoming Medicaid provides long-term care services through a Long-Term Care Home and Community Based Services (LTC/HCBS) waiver program. Wyoming's LTC/HCBS waiver provides in-home services to recipients 19 years of age and older who require services equivalent to a nursing facility level of care. Available services include case management, personal care, respite, adult day care, non-medical transportation, personal emergency response system, home-delivered meals and skilled nursing care.

The LTC/HCBS waiver includes a Consumer Directed Care option for recipients who are capable of directing their own care. This option allows recipients to recruit, hire, train, schedule, evaluate and terminate their own personal care assistants.

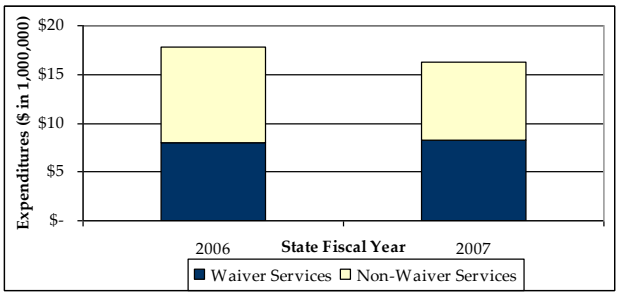
Wyoming Medicaid requires a functional assessment to determine medical necessity for LTC/HCBS waiver services. Wyoming Medicaid will not reimburse for services to an individual who has not met the level of care assessment criteria.

Long-Term Care Home- and Community-Based Services Waiver Expenditures

There were 1,636 LTC/HCBS waiver recipients in SFY 2007, an increase of five percent from SFY 2006. This number is more than the 1,150 available waiver slots in SFY 2007 because a certain portion of the waiver recipients leave the waiver program and are replaced by new recipients.

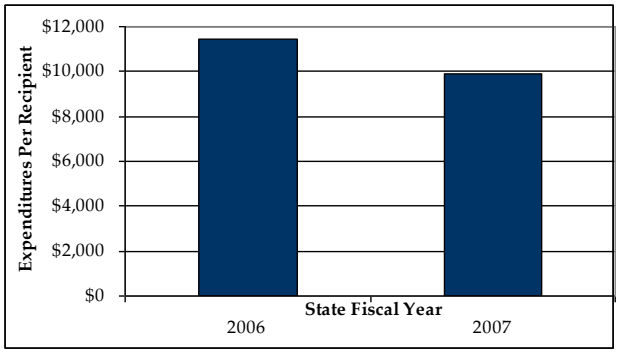
Waiver services expenditures increased by four percent from $8.0 million in SFY 2007 to $8.3 million in SFY 2007. Waiver and non-waiver expenditures for LTC/HCBS waiver recipients totaled $16.2 million in SFY 2007, a decrease of nine percent from SFY 2006.[43] Non-waiver services accounted for 49 percent of expenditures for LTC/HCBS waiver recipients, as shown in Figure 2. The decrease in total expenditures for LTC/HCBS recipients is attributable to the decrease in expenditures for non-waiver services.

Figure 2: All Waiver and Non-Waiver Expenditures for LTC Waiver Recipients — SFYs 2006-2007



Total waiver and non-waiver expenditures per recipient decreased by 13 percent from $11,423 per recipient in SFY 2006 to $9,919 per recipient in SFY 2007, as shown in the following figure.

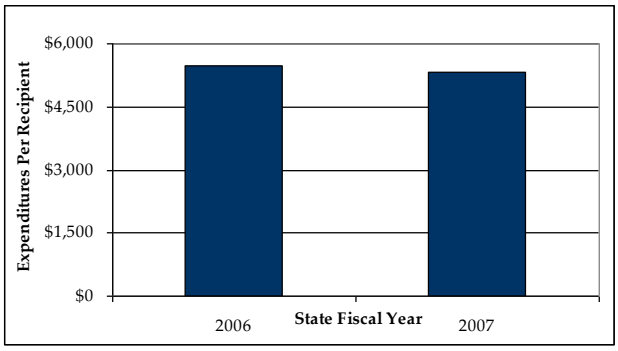
Figure 3: Total Expenditures for LTC Recipients Per Recipient — SFYs 2006-2007



LTC/HCBS waiver expenditures per recipient decreased by three percent from $5,491 in SFY 2006 to $5,336 in SFY 2007, as shown in the following figure.

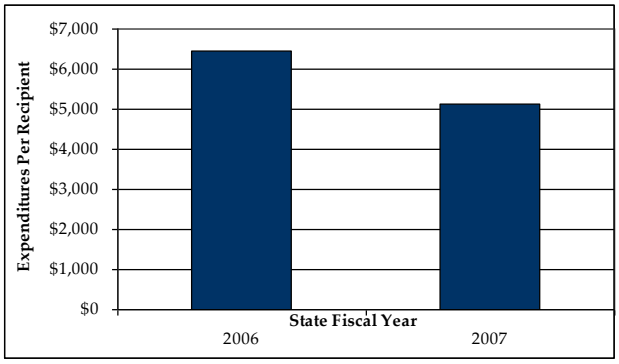
[43] Non-waiver services for waiver recipients are duplicated in other sections of the Annual Report.

Figure 4: Expenditures for LTC Waiver Services Per Recipient— SFYs 2006-2007



Non-waiver expenditures per recipient decreased by 20 percent from $6,448 per recipient in SFY 2006 to $5,140 per recipient in SFY 2007, as shown in the following figure.

Figure 5: Expenditures for Non-Waiver Services Per LTC Recipient— SFYs 2006-2007



Long-Term Care Home- and Community-Based Services Waiver Reimbursement Methodology

Each LTC/HCBS waiver recipient has a plan of care prepared by a case manager and a budget for the required services, as approved by the Aging Division. Wyoming Medicaid limits the dollar amount of the plan of care to a monthly or yearly cap per person, according to the established care plan.

Wyoming Medicaid reimburses providers according to the lower of the fee schedule or the provider's usual and customary charges. Wyoming Medicaid funds the waiver through legislative appropriation based on the cost per client in the previous two-year period. The Legislature considers increases as exception budget requests.

Current Issues

The Wyoming Legislature, through SF0089, recently authorized Wyoming Medicaid to expand the number of LTC/HCBS waiver slots from 1,150 to 1,450 as of July 1, 2007. In this Act, the Legislature also authorized an increase of $3.00 per hour for waiver services provided on an hourly basis and an increase of 17.6 percent above the prevailing rate for non-hourly waiver services.

Rates for personal care attendant services were increased to $20. Self-directed services rates increased to $12.

Assisted Living Facility Waiver Description

Wyoming Medicaid also provides long-term care services through an Assisted Living Facility (ALF) waiver program.

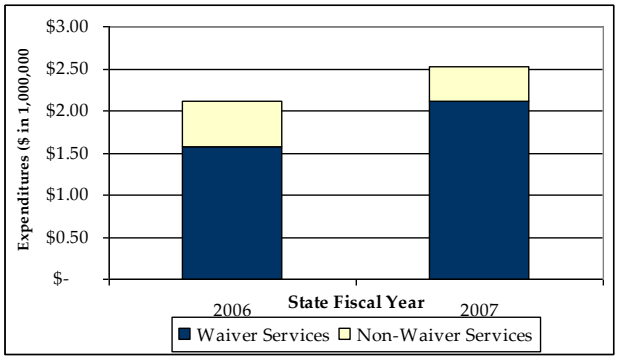
The ALF waiver allows recipients 19 years of age and older who require services equivalent to a nursing facility level of care to receive services in an ALF. Each waiver recipient has a plan of care prepared by a case manager.

Wyoming Medicaid requires a functional assessment to determine medical necessity for ALF waiver services. Wyoming Medicaid will not reimburse for services to an individual who has not met the level of care assessment criteria.

Assisted Living Facility Waiver Recipients and Expenditures

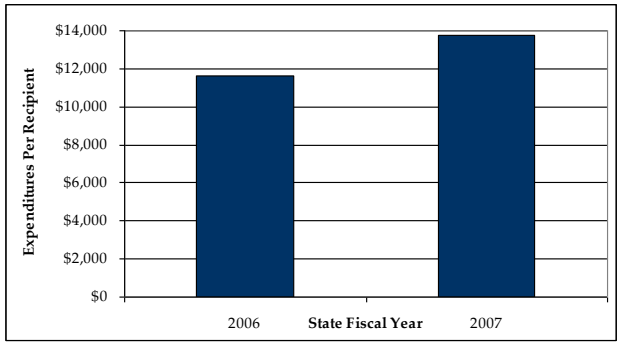
There were 175 ALF waiver recipients in SFY 2007, an increase of two percent from SFY 2006. As shown in the figure below, expenditures for all waiver and non-waiver services for ALF waiver recipients totaled $2.5 million in SFY 2007, an increase of 20 percent from SFY 2006. Non-waiver services accounted for 16 percent of total expenditures for waiver recipients in 2007.

Figure 6: Waiver and Non-Waiver Expenditures for ALF Recipients — SFYs 2006-2007



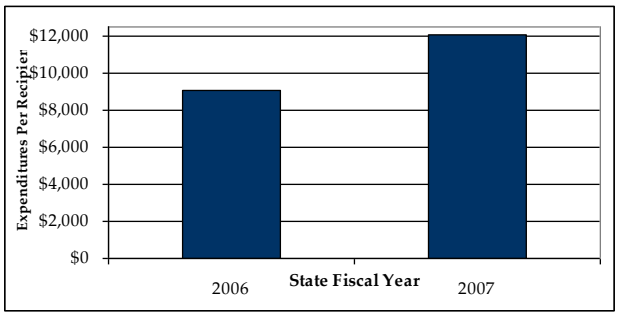
Total waiver and non-waiver expenditures per recipient increased by 18 percent from $11,618 per recipient in SFY 2006 to $13,758 per recipient in SFY 2007, as shown in Figure 7.

Figure 7: Total Expenditures for ALF Recipients Per Recipient — SFYs 2006-2007



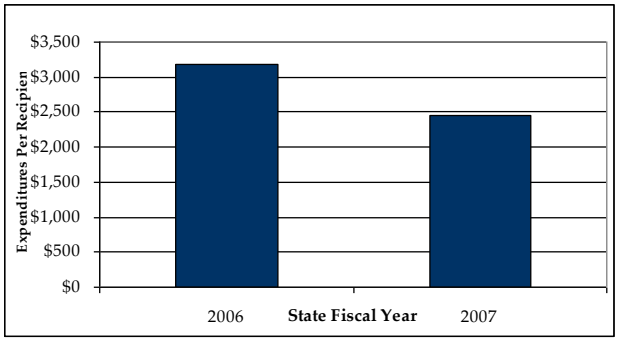
ALF waiver expenditures per recipient increased by 33 percent from $9,105 per recipient in SFY 2006 to $12,102 per recipient in SFY 2007, as shown in the following figure.

Figure 8: Expenditures for ALF Waiver Services Per Recipient — SFYs 2006-2007



Non-waiver expenditures per recipient decreased by 23 percent from $3,189 per recipient in SFY 2006 to $2,447 per recipient in SFY 2007, as shown in the following figure.

Figure 9: Expenditures for Non-Waiver Services Per ALF Recipient — SFYs 2006-2007



Assisted Living Facility Waiver Reimbursement Methodology

Wyoming Medicaid reimburses for ALF nursing care provided by the facility at a per diem rate determined by the functional assessment score. The per diem includes the required personal care, 24-hour supervision and medication assistance up to a yearly or monthly cap. Wyoming Medicaid also reimburses a separate fee for case management services. ALF recipients pay their own room and board.

Wyoming Medicaid funds the waiver through legislative appropriation based on the cost per client in the previous two-year period. The legislature considers increases as exception budget requests.

Current Issues

There are currently only 10 ALFs in Wyoming, half of which are in Casper and Cheyenne. However, more facilities are currently being built in Douglas and Campbell counties.

The Wyoming Legislature recently passed SF0089, which allows Wyoming Medicaid to increase the number of ALF slots from 146 to 168 as of July 1, 2007. Additional funds provided by this legislation allowed Wyoming Medicaid to increase the per diem rate for ALFs. However, there were no funds available to increase the case management fee. SF0089 also provides appropriations for adult foster care and other living arrangements, and directs Wyoming Medicaid to investigate current access to adult day care services.

Nursing Facility Services Description

Wyoming Medicaid covers nursing facility services for individuals who are no longer able to live in the community. A nursing facility is an institution (or a distinct part of an institution), which is not primarily for the care and treatment of mental diseases, and provides: [44]

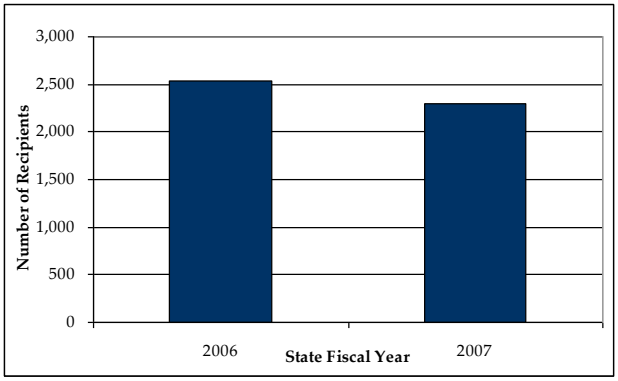
- Skilled nursing care and related services for residents who require medical or nursing care
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons
- Health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities

Nursing Facility Services Recipients and Expenditures

There were 2,551 Medicaid recipients who received nursing facility services in SFY 2007, a decrease of 6.1 percent from SFY 2006, as shown in Figure 10.

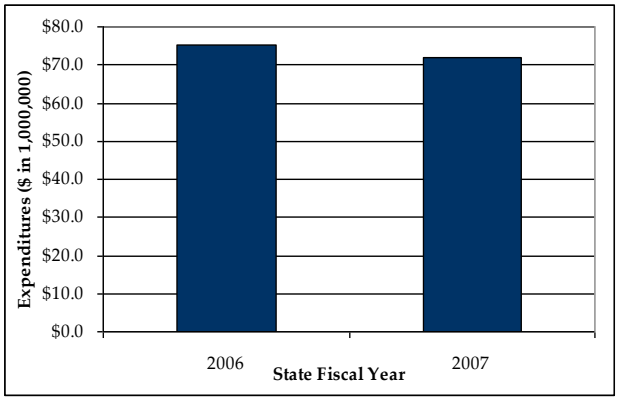
Wyoming Medicaid notes that multiple factors may have contributed to the decrease in nursing facility expenditures, such as increased use of the ALF and LTC/HCBS waivers in combination with cost containment efforts and programs such as Project Out, which provides assistance to re-integrate former nursing facility residents into the community.

Figure 10: Nursing Facility Services Recipients — SFYs 2006-2007



Total nursing facility service expenditures were $72.0 million in SFY 2007, a decrease of five percent from SFY 2006, as shown in the following figure.[45]

Figure 11: Nursing Facility Service Expenditures — SFYs 2006-2007

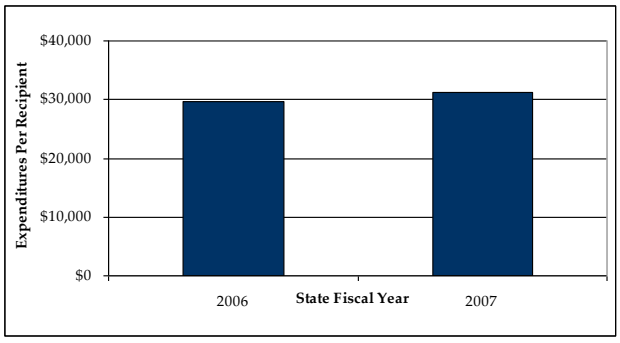


Nursing facility expenditures per recipient increased by four percent from $28,436 per recipient in SFY 2006 to $29,640 per recipient in SFY 2007, as shown in the following figure.

[44] The Wyoming Medicaid Rules cite the definition of Nursing Facility in 42 USC § 1396r, Requirements for Nursing Facilities.

[45] Expenditures do not include additional expenditures that require prior authorization for services provided to a high-cost extraordinary recipient. Wyoming Medicaid estimates that these extraordinary costs are approximately two percent of nursing facility costs.

Figure 12: Nursing Facility Expenditures Per Recipient — SFYs 2006-2007



Nursing Facility Services Reimbursement Methodology

Wyoming Medicaid reimburses a per diem rate for nursing facilities. This rate covers routine services and reserve bed days. Routine services include room, dietary, laundry, nursing, minor medical surgical supplies, non-legend pharmaceutical items (including over-the-counter drugs and products, insulin and diabetic supplies) and the use of equipment and facilities. Wyoming Medicaid may reimburse for reserve bed days during a resident's temporary absence.

Wyoming Medicaid calculates facility per diem rates each fiscal year using facility-specific cost data. A facility's per diem rate may not exceed the maximum rate established by Wyoming Medicaid. Wyoming Medicaid last rebased nursing facility rates in July 2006. The current median per diem rate is $146.

Wyoming Medicaid reimburses separately, outside of the facility's per diem, for physician visits and for prescription drugs for residents of a nursing facility.

Wyoming Medicaid provides additional reimbursement outside of the per diem rate on a monthly basis for services provided to an extraordinary recipient. Wyoming Medicaid determines per case rates for extraordinary recipients based on relevant cost and medical records.

Current Issues

Wyoming State Statute imposes a moratorium on new nursing facility construction if occupancy rates are below 84 percent. Statewide, nursing home occupancy rates have been holding steady at 82 percent over the last six years.[46] Nursing facility occupancy rates in Cheyenne and Casper are currently at 90 percent.[47]

Since the current occupancy rate in these communities is greater than 84 percent, the State moratorium on new nursing facility construction would allow new nursing facility beds in these communities. There has been no new nursing facility construction, perhaps because nursing facilities in Cheyenne and Casper may be reluctant to build due to the shortage of staff available to care for nursing facility residents. Existing facilities are currently experiencing difficulty hiring and retaining needed staff. One factor contributing to the workforce shortages is competition for staff with Wyoming's energy extraction industries.[48]

There appears to be a particular need for staff trained to care for geriatric psychiatric residents. Currently, Wyoming Medicaid transfers residents with high-level psychiatric needs to out-of-state facilities.

To address this issue, effective July 1, 2007, the Wyoming Legislature appropriated $102,000 to train clinical staff who work in Community Mental Health and Substance Abuse Centers and nursing home staff who work with older adults with mental health and substance abuse problems.

In SFY 2007, Wyoming Medicaid rebased rates based on SFY 2004 cost data. The legislature approved $4.2 million in funding for this increase.

[46] Information provided by State staff during February 2007 planning and reporting meetings.
[47] Ibid.
[48] Ibid.

Table A: Long-Term Care Total Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$84,883,408	4,157	$ 20,419
2007	82,405,271	4,033	20,433
Percent Change SFYs 2006-2007	-2.9	-3.0	0.1

Table B: LTC/HCBS Total Services for Waiver Recipients: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 17,762,727	1,555	$ 11,423
2007	16,227,907	1,636	9,919
Percent Change SFYs 2006-2007	-8.6	5.2	-13.2

Table C: LTC/HCBS Waiver Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 7,961,370	1,450	$ 5,491
2007	8,302,526	1,556	5,336
Percent Change SFYs 2006-2007	4.3	7.3	-2.8

Table D: LTC/HCBS Non-Waiver Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 9,801,357	1,520	$ 6,448
2007	7,925,381	1,542	5,140
Percent Change SFYs 2006-2007	-19.1	1.5	-20.3

Table E: ALF Total Services for Waiver Recipients: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 2,114,523	182	$ 11,618
2007	2,531,559	184	13,758
Percent Change SFYs 2006-2007	19.7	1.1	18.4

Table F: ALF Waiver Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 1,566,074	172	$ 9,105
2007	2,117,932	175	12,102
Percent Change SFYs 2006-2007	35.2	1.7	32.9

Table G: ALF Non-Waiver Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 548,449	172	$ 3,189
2007	413,627	169	2,447
Percent Change SFYs 2006-2007	-24.6	-1.7	-23.2

Table H: Nursing Facilities Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 75,355,964	2,535	$ 29,726
2007	71,984,813	2,302	31,271
Percent Change SFYs 2006-2007	-4.5	-9.2	5.2

Description

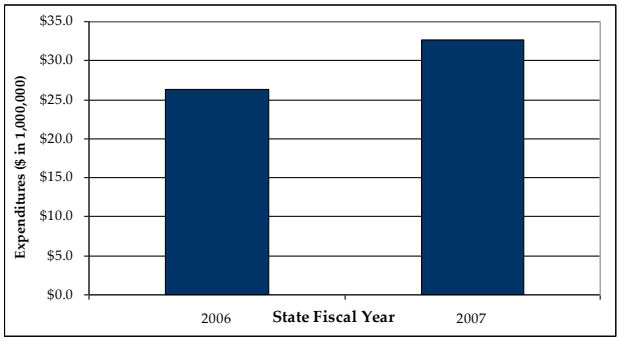
Mental health and substance abuse services include services provided by Community Mental Health Centers (CMHCs), Mental Health Professional providers, Substance Abuse providers, Children's Mental Health Waiver providers and Residential Treatment Centers (RTC). Inpatient hospital expenditures for mental health and substance abuse services are discussed in the hospital section of the Annual Report.

Mental health services are also provided by the Wyoming State Hospital — the State's only Institute for Mental Disease. Expenditures for these services are excluded from this section. The Wyoming State Hospital is for patients who are medically fragile, combative or whom the legal system placed in the hospital after it classified them as not guilty of committing crimes due to mental illness.

Expenditures

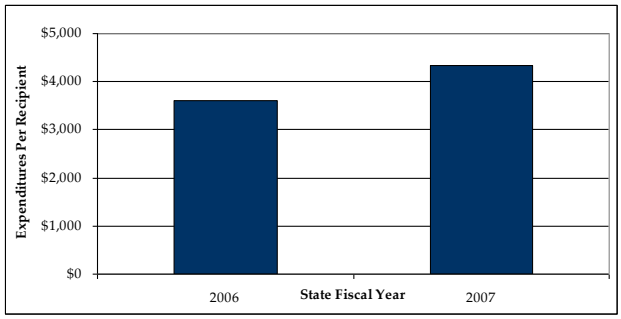
Mental health and substance abuse expenditures totaled $32.6 million in SFY 2007, an increase of 24 percent from SFY 2006, as shown in the following figure. Mental Health expenditures were nine percent of total Medicaid expenditures in SFY 2007.

Figure 1: Total Mental Health and Substance Abuse Expenditures — SFYs 2006-2007



Mental health expenditures per recipient were $4,326 in SFY 2007, an increase of 20 percent from SFY 2006, as shown in the following figure.

Figure 2: Total Expenditures for Mental Health and Substance Abuse Services Per Recipient — SFYs 2006-2007



Most mental and substance abuse expenditures were for RTC services, accounting for 56 percent of total metal health and substance abuse services. Mental health and substance abuse providers, including CMHCs, accounted for 43 percent of total mental health and substance abuse expenditures, while the children's mental health waiver accounted for less than one percent.

Mental health and substance abuse hospital expenditures are discussed in the hospital section of the Annual Report.

Reimbursement Methodology

Specific reimbursement methodologies for the mental health and substance abuse services are described in the subsections that follow. The tables following each subsection provide detail regarding expenditures and recipients for SFY 2006 and SFY 2007.

The Wyoming State Hospital receives a per diem reimbursement rate of $520 per day per Medicaid eligible patient.

Current Issues

Due to the aging of the Wyoming population, Wyoming Medicaid reports that there is a growing need for geriatric psychiatric services in Wyoming and a lack of appropriately trained providers in the State.

Effective July 1, 2007, the Wyoming Legislature appropriated:

- $1.3 million to the Wyoming State Hospital for one year to increase the hospital's capacity to treat an additional 14 mentally ill adult acute care patients.
- $102,000 to train clinical staff who work in community mental health and substance abuse centers and nursing home staff who work with older adults with mental health and substance abuse problems.

Current issues specific to CMHCs, Mental Health Professionals, Children's Mental Health Waiver and RTCs are described in the subsections that follow.

CMHCs and Stand-alone Mental Health and Substance Abuse Professionals Description

Mental health and substance abuse services are provided by Community Mental Health Centers (CMHCs) as well as stand-alone mental health and substance abuse professionals. Services provided by Residential Treatment Centers (RTC) and Mental Health Waiver providers are discussed separately in the sections that follow.

Wyoming Medicaid covers medically necessary psychiatric services provided by a physician (i.e. psychiatrists), or when provided by other mental health practitioners who work under a physician, including:

- Licensed clinical psychologists
- Licensed clinical social workers
- Masters level counselors
- Psychiatric clinical nurse practitioners
- Physician assistants

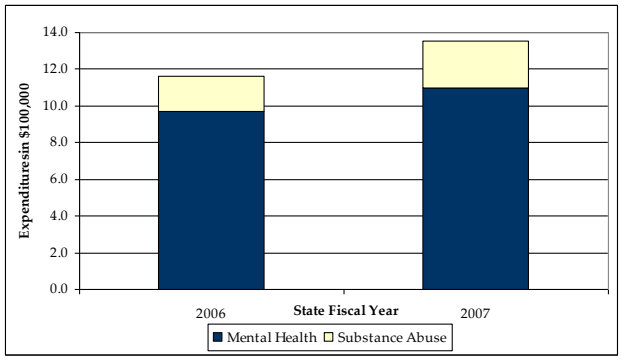
As of March 1, 2003, Wyoming Medicaid also reimburses independently practicing clinical psychologists.

CMHCs are community-based facilities that provide for the prevention and treatment of mental illness. Mental health and substance abuse services provided by CMHCs include mental health assessments, individual and group therapy, rehabilitation services and case management.

CMHCs and Mental Health and Substance Abuse Professionals Expenditures[49,50]

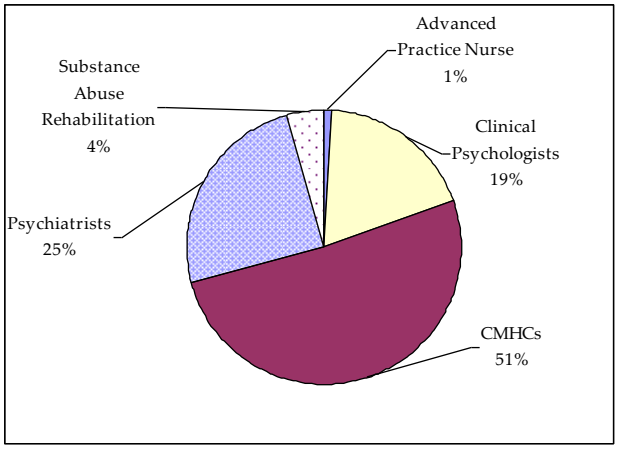
Medicaid expenditures were $13.6 million in SFY 2007, an increase of 17 percent from SFY 2006, as shown in the following figure. Mental health services expenditures accounted for 81 percent of the total expenditures for mental health and substance abuse services in SFY 2007 and 83 percent in 2006.

Figure 3: CMHC and Other Mental Health and Substance Expenditures — SFYs 2006-2007



In 2007, CMHCs accounted for 51 percent of mental health and substance abuse expenditures, as shown in the following figure.

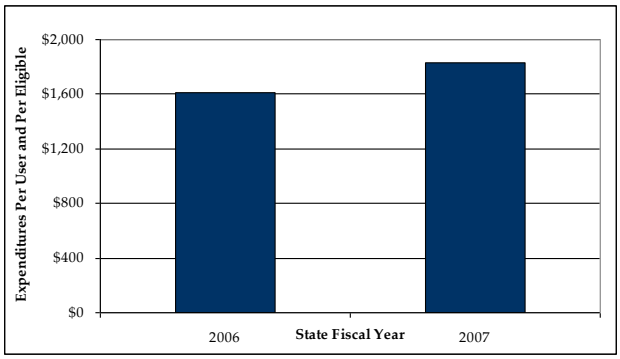
Figure 4: Percent of Total Mental Health and Substance Abuse Expenditures by Provider Type SFY 2007



Expenditures per recipient were $1,827 in SFY 2007, an increase of 13 percent from SFY 2006, as shown in the following figure.

[49] As discussed in this section, Mental Health services are defined as ICD-9 diagnoses codes 293 through 302.9 and 306 through 313.9. Substance Abuse diagnoses codes are defined as 291 through 292.9 and 303 through 305.9.
[50] Expenditures exclude non-psychiatrist physicians and providers that bill under a non-psychiatrist physician.

Figure 5: Expenditures for CMHCs and Other Mental Health and Substance Abuse Services Per Recipient — SFYs 2006-2007



An analysis of claims by primary diagnoses code indicates that claims with the top five diagnosis codes (determined by expenditures) accounted for 27 percent of expenditures for CMHCs and mental health and substance abuse professionals. The following table provides an overview of expenditures by the top five diagnoses codes in SFY 2007.

Table 1: Expenditures for Claims with Top Five Diagnoses Codes – SFY 2007 (by total expenditures)

Diagnosis Code Description	Code	Expenditures
Oppositional Defiant Disorder	313.81	$ 975,905
Post-traumatic Stress Disorder	309.81	885,012
Depressive Disorder not Elsewhere Classified	311	741,996
Unspecified Adjustment Reaction	309.9	701,528
Unspecified Disturbance of Conduct	312.9	385,666
Expenditures for Top Five Codes		$ 3,690,125

Of the 7,423 recipients of mental health and substance abuse services in SFY 2007, 130 had at least one claim with a mental health primary diagnosis and at least one claim with a substance abuse primary diagnosis. Mental health and substance abuse expenditures for these recipients with dual diagnoses were $448,750 in SFY 2007.

Mental Health and Substance Abuse Reimbursement Methodology

Wyoming Medicaid reimburses for mental health and substance abuse services according to the lower of the provider's usual and customary fee or the fee specified in the Medicaid fee schedule. The fee schedule amounts for mental health and substance abuse procedure codes billed by physicians, psychologists and advanced practice nurses were calculated using a Resource Based Relative Value Scale (RBRVS) approach, which is described in more detail in the Physicians and other Practitioner section of this Report.

CMHCs and other master's-level professionals use HCPCs Level II codes to bill for mental health and substance abuse services. Wyoming Medicaid determined fees for these services through comparisons to private sector behavioral health rates.

Current Issues

Wyoming Medicaid is planning to begin a study of CMHC provider costs to better understand the costs for mental health and substance abuse services and establish a framework for developing reimbursement strategies that recognize provider performance and support quality initiatives.

Effective July 1, 2007, the Wyoming Legislature appropriated:

- $1.4 million for one year to the Substance Abuse Division to divide among community substance abuse treatment centers to increase salaries of direct care staff
- $1.8 million for one year to the Mental Health Division, to divide among CMHCs, to increase salaries of direct care staff
- $384,000 to the Wyoming State Hospital and an additional $829,000 to the Department for one year to implement both inpatient and regional residential treatment programs to treat individuals with co-occurring diagnoses of severe, persistent mental illness and substance abuse, dependence or addiction

- $2.1 million to increase capacity of community substance abuse treatment centers to provide residential treatment services
- $2.2 million to the Mental Health Division to enable CMHCs to provide community-based housing and residential services for clients with serious and persistent mental illness to allow clients to remain in an independent living situation
- Additional monies to expand telepsychiatry equipment and services
- $2.9 million to the Department to increase reimbursement for mental health and substance abuse treatment services. Providers received a rate increase of 24 percent from $70 per hour to $87 per hour. The State portion of the increase took effect July 1, 2007. The Federal match portion of the increase took effect September 1, 2007.

Children's Mental Health Waiver Description

Wyoming Medicaid implemented the Children's Mental Health Waiver program in July 2006. The goal of the waiver is to allow youth with serious emotional disturbances who need mental health treatment to remain in their home communities. Waiver recipients must be between the ages of 4 and 20, have need that meet the definition of serious emotional disturbance, be financially eligible for Medicaid and meet specific clinical criteria. Children's Mental Health Waiver recipients receive all Medicaid services while participating in the waiver program.

Each recipient has an Individualized Service Plan and budget developed by a team of providers and the child's family. Waiver recipients receive non-clinical services provided as outlined in an Individual Service Plan, including family care coordination, family training and support and individualized child training and support.

Children's Mental Health Waiver Expenditures

Expenditures for waiver services totaled $2,189 in SFY 2007 for two waiver recipients.

Children's Mental Health Waiver Reimbursement Methodology

Wyoming Medicaid reimburses for waiver services according to the lower of the provider's usual and customary fee or the fee specified in the Medicaid fee schedule, similar to fees for CMHCs and other comparable providers for similar services. However, Wyoming Medicaid reduced reimbursement levels slightly, since the waiver's proposed provider base consisted of individuals without Master's degrees (i.e., Bachelor's level providers).

Wyoming Medicaid will evaluate current reimbursement rates before waiver renewal to assess cost neutrality of the waiver. Determining cost neutrality in the original waiver application was difficult because the Department could not compare data regarding the projected cost of services under this waiver to previous data; Wyoming Medicaid previously grouped waiver services into the residential rate.

Wyoming Medicaid is also considering adjusting rates to be consistent with reimbursement levels used in a children's mental health federal grant program.

Current Issues

Wyoming Medicaid is continuing to target children who may be available for the waiver and developing a provider base for the waiver services. To support new and existing providers, Wyoming Medicaid is considering altering reimbursement levels and streamlining billing processes, especially for independent providers.

Residential Treatment Center Description

Wyoming Medicaid covers psychiatric residential treatment for individuals under age 21 in a psychiatric Residential Treatment Center (RTC).

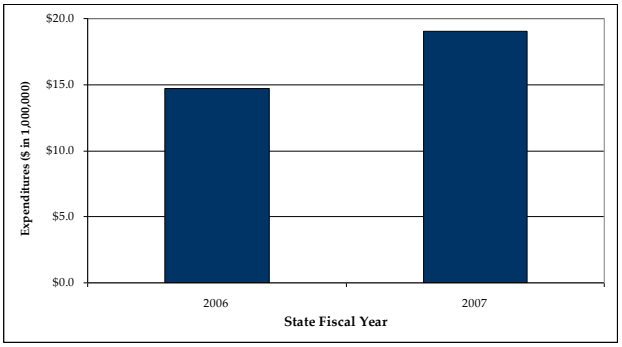
Psychiatric RTC services are provided to individuals who require extended care beyond acute psychiatric stabilization or extended psychiatric services. These services address long-standing behavioral disturbances, which are not usually responsive to shorter term care.

Each recipient has an Individualized Plan of Care developed by a team of physicians and mental health specialists employed by or providing services in the facility. This plan confirms the need for residential psychiatric care and is designed to achieve the recipient's discharge from the inpatient status at the earliest possible time. The team of specialists reviews this plan at least every 30 days and documents responses to treatment and any revised plans. This plan assists in determining the medical necessity of a continued stay, or documenting progress towards goals to assist with discharge planning.

Residential Treatment Center Expenditures

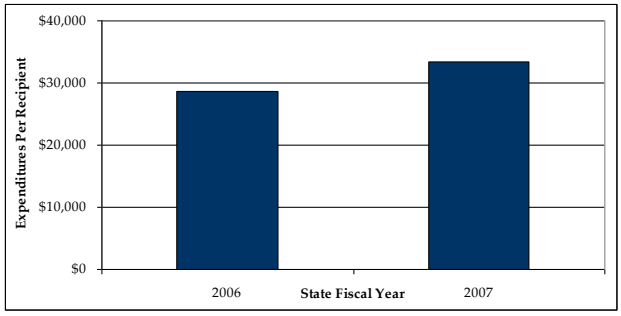
Total Medicaid RTC expenditures were $19.1 million in SFY 2007, a 30 percent increase from SFY 2006, as shown in the following figure.

Figure 6: RTC Expenditures — SFYs 2006-2007



RTC expenditures per recipient were $33,326 in SFY 2007, an increase of 17 percent from SFY 2006, as shown in the following figure.

Figure 7: Expenditures for RTC Services Per Recipient — SFYs 2006-2007



Residential Treatment Center Reimbursement Methodology

Wyoming Medicaid reimburses for RTC services using an all-inclusive, negotiated per diem rate; providers bill professional services separately. The negotiated rate includes the facility's base rate for room and board plus the reasonable, documented costs of providing medically necessary services. The negotiated rate may not exceed the facility's usual and customary charge.

Wyoming Medicaid negotiates provider rates using Department of Family Services RTC base rates and facility-specific financial data, with some facilities receiving varied rates based on the different levels of care they provide. Wyoming Medicaid's RTC rates range from approximately $170 per day for basic RTC services to $636 per day for out-of-state highly specialized eating disorder treatment.

Current Issues

Wyoming Medicaid is conducting the third year of a cost study of residential treatment providers, along with two other State payers — the Department of Family Services and the Department of Education. The Departments used data from State Fiscal Year 2006 cost data to develop rate requests for the State Fiscal Year 2009-2010 biennium. The Departments have convened a provider technical advisory group

to recommend improvements for the State Fiscal Year 2007 cost report and the collection process.

To receive Medicaid reimbursement for room and board costs, the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) must accredit RTCs enrolled in Wyoming Medicaid.

Of the 14 RTCs in Wyoming, four free-standing centers and one hospital-based center meet the certification requirements to provide both mental health services and room and board to Medicaid eligible children. The remaining 11 facilities can provide mental health services only to Medicaid eligible children, but the Department of Family Services reimburses for room and board expense, which is ineligible for federal match.

Table A: Mental Health and Substance Abuse Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 26,315,152	7,311	$ 3,599
2007	32,630,059	7,542	4,326
Percent Change SFYs 2006-2007	24.0	3.2	20.2

Table B: CMHCs and Other Mental Health and Substance Abuse Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 11,632,499	7,213	$ 1,613
2007	13,561,013	7,423	1,827
Percent Change SFYs 2006-2007	16.6	2.9	13.3

Table C: Children's Mental Health Waiver Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	N/A	N/A	N/A
2007	$ 2,189	2	$ 1,095
Percent Change 2006-2007	N/A	N/A	N/A

Table D: RTC Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures	Number of Recipients	Per Recipient Expenditures
	(A)	(B)	(C)=(A/B)
2006	$ 14,682,654	513	$ 28,621
2007	19,069,046	571	33,396
Percent Change 2006-2007	29.9	11.3	16.7

PHYSICIAN AND OTHER PRACTITIONERS

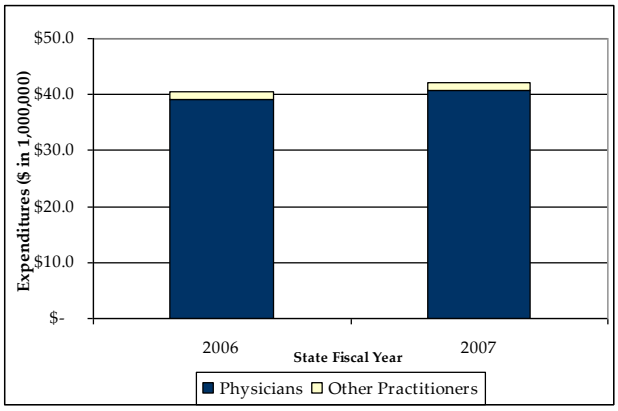
Description

Wyoming Medicaid uses the Resource-Based Relative Value Scale (RBRVS) Medicaid physician fee schedule to pay for medical services provided by several categories of practitioners, including physicians, psychiatrists, physician assistants, physical and occupational therapists, ophthalmologists and nurse practitioners.

Expenditures

Expenditures for physicians and other practitioners totaled $42.04 million in SFY 2007, an increase of 4.1 percent from SFY 2006 expenditures of $40.4 million, as shown in the following figure.[51] Physician and other practitioners expenditures were 11.2 percent of total Medicaid expenditures in SFY 2007.

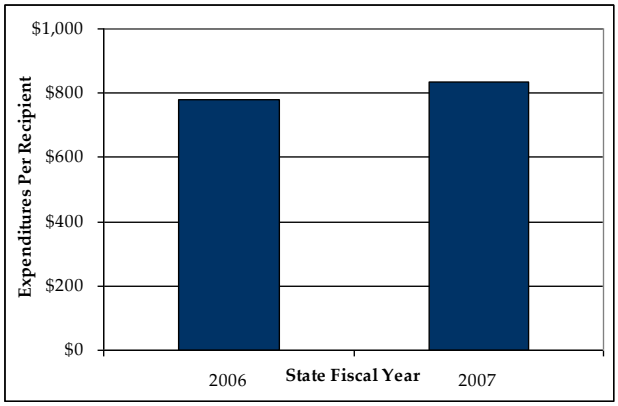
Figure 1: Physician and Other Practitioners Expenditures — SFY 2006-2007



The physician expenditures reported in this section exclude services billed by psychiatrists and routine vision services performed by ophthalmologists. Discussions of expenditures for these two service areas are found in the Mental Health and Vision sections of this Report (psychiatrists and ophthalmologists, respectively). Expenditures for psychiatrists were $2.17 million in SFY 2007 as compared to $26,833 in expenditures for routine eye exam services performed by ophthalmologists.

Physician and other practitioner expenditures per recipient increased by 7 percent from $780 per recipient in SFY 2006 to $833 per recipient in SFY 2007, as shown in the following figure.

Figure 2: Physician and Other Practitioners Expenditures per Recipient— SFY 2006-2007



Reimbursement Methodology

Wyoming Medicaid pays the lower of the provider's usual and customary charges or the RBRVS fee schedule for physician and other practitioners' services, excluding some select providers and services.

The RBRVS fee schedule is determined by a set of relative values multiplied by a conversion factor. The relative value of each service is the sum of the relative value units (RVUs), representing physician work, practice expense and professional liability insurance. The relative value multiplied by a conversion factor and number of service units creates the dollar payment amount.

Anesthesiologists are paid through a different fee schedule. The fee schedule for anesthesiologists is based on RVUs developed and published by the American Society of Anesthesiologists.

[51] Physician data excludes the psychiatrist provider taxonomy and routine eye exams (V72.0) for ophthalmologists. These expenditures are reported in the Mental Health and Vision sections. Physician data includes the taxonomy for anesthesiologists.

Wyoming Medicaid and the Wyoming Legislature have made several updates over time to the physician reimbursement methodology. In SFY 2007, Wyoming Medicaid updated Medicare RVUs from 2004 to 2006 Medicare RVUs and adjusted the conversion factor from $36.20 to $43.83 for physician services. A legislatively mandated increase in funding of approximately $1,490,000 for physician services, which includes approximately $280,000 for selected anesthesia services, provides for the conversion factor increase.

A study published in *Health Affairs* in 2004 shows that in 2003, overall Wyoming Medicaid physician fees were 40 percent above the national average — similar to Medicaid physician fees in Arizona and Nevada and slightly higher than fees paid in Idaho, Montana, Colorado and Utah. [52]

Current Issues

Implementing a standard annual rate of increase for physicians and other practitioners paid by the Medicaid physician fee schedule would allow for predictable payment levels over time and would reduce the need for ongoing, "one-time" legislative rate increases. Linking Wyoming's conversion factors and relative weights to Medicare rates may also support this process.

There are concerns that several areas of the state do not have enough providers and Wyoming Medicaid may need to increase efforts to recruit physicians and other practitioners. Specifically, there is a concern that there are not enough obstetricians in some areas of the state, and that many of the physicians in the largest pediatrics group in Cheyenne are reaching retirement. Many areas of the state are primary care Health Professionals Shortage Areas (HPSAs), including the counties of Big Horn, Carbon, Campbell, Hot Springs, Niobrara, Platte, Sweetwater, Uinta, Washakie and Weston.[53]

[52] Zuckerman, S., McFeeters, J., Cunningham, P. and Nichols, L, "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation," (June 23, 2004) p. W4-378.

[53] The Health Resource and Services Administration Health Professional Shortage areas are available by state and county at http://hpsafind.hrsa.gov/HPSASearch.aspx.

PHYSICIAN AND OTHER PRACTITIONERS

Table A: Physician and Other Practitioners Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 40,403,114	51,807	$ 780
2007	42,042,870	50,490	833
Percent Change SFYs 2006-2007	4.1	-2.5	6.8

Table B: Physician Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 39,218,661	$ 51,324	$ 764
2007	40,684,257	50,016	813
Percent Change SFYs 2006-2007	3.7	-2.6	6.5

Table C: Other Practitioner Services Only : Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 1,184,453	4,178	$ 284
2007	1,358,613	4,432	307
Percent Change SFYs 2006-2007	14.7	6.1	8.1

PRESCRIPTION DRUGS

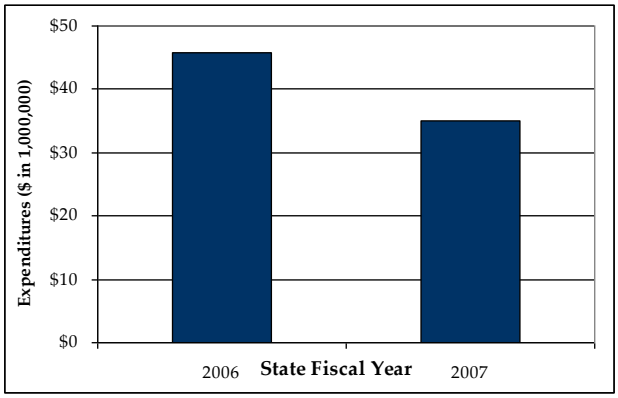
Description

Wyoming Medicaid covers most prescription drugs and specific over-the-counter drugs. A prescription and copayment are required for all drugs for most recipients. Exceptions may apply for specific products or conditions, such as pregnancy.

Expenditures[54]

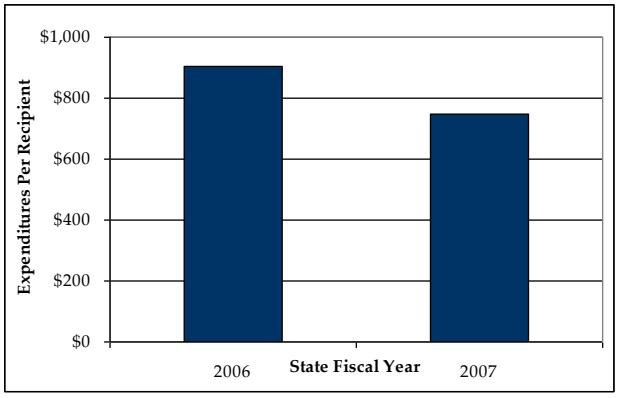
Medicaid prescription drugs expenditures, excluding rebate amounts, totaled $35.0 million in SFY 2007, a 23 percent decrease from SFY 2006, as shown in the following figure.[55] Expenditures were 9 percent of total Medicaid expenditures in SFY 2007.

Figure 1: Prescription Drugs Expenditures — SFY 2006-2007



Prescription drug expenditures per recipient were $744 in SFY 2007, a decrease of 18 percent from SFY 2006, as shown in the following figure.

Figure 2: Prescription Drugs Expenditures per Recipient — SFY 2006-2007



Prescription drugs rebate amounts were $12.7 million in SFY 2006 and $ 8.4 million for SFY 2007. The decreased rebate amount is due to the Part D population moving off of Medicaid, to successful cost containment measures and the reduction in Medicaid eligibles and prescription drug recipients (almost 8 percent).[56]

Reimbursement Methodology

Wyoming Medicaid pays for prescription drugs at the lower of the estimated acquisition cost of the ingredients, the Federal Upper Limit (FUL), the State Maximum Allowable Cost (SMAC) plus the dispensing fee, or the provider's usual and customary charge. The estimated acquisition cost is 89 percent of the average wholesale price (AWP) for the ingredients (more commonly known as the average wholesale price minus 11 percent).

The dispensing fee for physicians who provide pharmacy services is $2.00 per prescription; the dispensing fee for pharmacy claims is $5.00 per claim.

As of late 2007, the Wyoming Department of Health, Office of Pharmacy Service had designated

[54] Data includes expenditures for pharmacies only and does not take into account rebate amounts.

[55] Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90), the Medicaid Drug Rebate Program requires a drug manufacturer to enter into a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients.

[56] The Medicare Modernization Act of 2003 created Medicare Part D, which established pharmacy coverage for all Medicare beneficiaries, including dual eligibles, effective January 1, 2006. Pharmacy costs for these individuals shifted from Medicaid to Medicare.

preferred drugs in nine drug groups. Wyoming Medicaid's Preferred Drug List Advisory Committee continues to review additional drug groups for preferred status at its quarterly meetings.

Wyoming Medicaid recipients pay copayments for prescription drugs as follows: $1.00 for generics, $2.00 for preferred drug list brand medications and $3.00 for other brand medications. Nursing home residents, pregnant women and children younger than 21 years of age are exempt from copayments. However, long -term care waiver clients and assisted living facility clients are no longer exempt from copayments.

Current Issues

Effective January1, 2007, the Deficit Reduction Act required that the Medicaid FUL for pharmacy be based on 250 percent of the lowest Average Manufacture's Price (AMP) rather than on 150 percent of the lowest price published in the national compendia. Drug manufacturers are required to report AMP data on their drugs to CMS monthly, and CMS provides AMP data to states monthly and posts AMP on a website at least quarterly. Wyoming Medicaid will evaluate the need to change reimbursement strategies based on the new FUL amounts.

Wyoming Medicaid is also considering the possibility of expanding the SMAC list to encompass single-source brand products as well as generic drugs. Currently, SMAC rates on multi-sources drugs are updated on a quarterly basis and as needed. The Department annually conducts a large pricing survey to determine actual acquisition costs specific to Wyoming pharmacies. The Office of Pharmacy Services is currently working with the University of Wyoming on a rural health pharmacy study, which will help determine an appropriate dispensing fee.

Cost containment efforts have included pharmacy lock-in to support appropriate use of narcotic pain medications, updated claims processing system edits and pharmacy-specific fraud and abuse detection.[57] These efforts, along with the preferred drug list, a state maximum allowable cost program to reduce reimbursement for multi-source medications, and a generic mandatory program requiring the use of a generic drug over a brand name drug have resulted in millions of dollars in savings for Wyoming Medicaid, according to the Plan for Improvement of the Wyoming Medicaid Program. Wyoming Medicaid also implemented a SmartPA Prior Authorization system, which allows Wyoming Medicaid to more efficiently automate and evaluate prior authorization requests. In addition, the Pharmacy Program will start obtaining supplemental rebates in early 2008. Supplemental rebates are in addition to the rebates mandated by participation in the Medicaid program. Pharmaceutical companies agree to additional rebates for drugs that are included on the state's preferred drug list. Wyoming Medicaid anticipates that this will result in a substantial increase in the rebate dollars received for prescription medications.

[57] Medicaid may restrict or "lock-in" recipients to a certain provider if the recipient's utilization of services is documented as being excessive. This program is intended to prevent Medicaid recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

Table A: Prescription Drugs Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 44,943,765	49,791	$ 903
2007	34,364,661	45,894	749
Percent Change SFYs 2006-2007	-23.5	-7.8	-17.1

RADIOLOGY

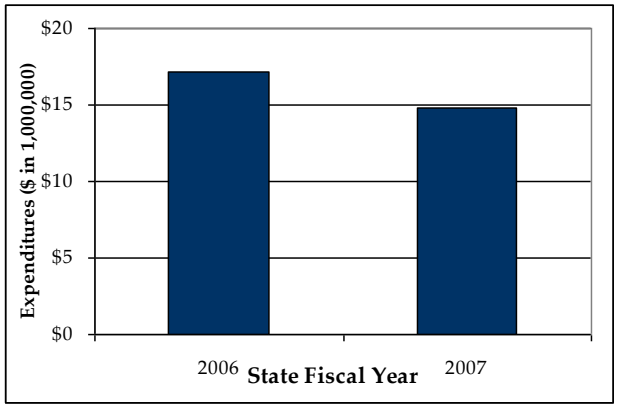
Description

Wyoming Medicaid covers radiology services including x-ray, screening mammography, ultrasound, radiation therapy and nuclear medicine services, if ordered by a physician or a nurse practitioner.

Expenditures

Radiology expenditures for SFY 2007 totaled $14.8 million, a decrease of 14 percent from $17.2 million in SFY 2006, as shown in the following figure. Radiology expenditures were four percent of total Medicaid expenditures in SFY 2007.

Figure 1: Radiology Expenditures — SFYs 2006-2007



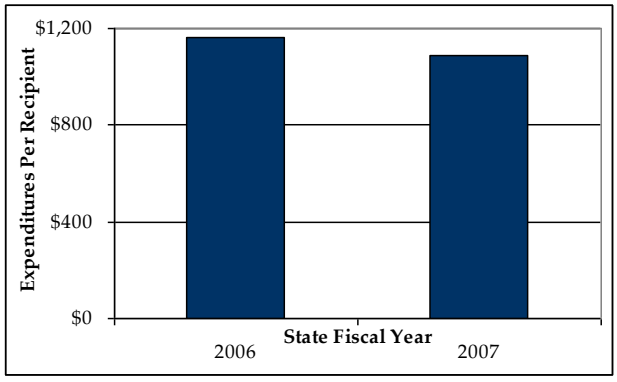
An analysis of SFY 2007 claims by procedure code revealed that claims with the top five codes (determined by expenditures) accounted for $3.1 million, or 21 percent, of radiology expenditures. The following table provides an overview of expenditures for the top five procedure codes in SFY 2007.

Table 1: Expenditures for Top Five Procedure Codes – SFY 2007

Procedure Code Description	Procedure Code	Expenditures
Radiologic Examination, Chest	71010	$ 901,100
Radiologic Examination, Chest; Two Views	71020	$ 883,458
Computed Tomography, Head	70450	$ 474,412
Computed Axial Tomography, Abdomen	74160	$ 452,790
Radiologic Examination, Abdomen	74000	$ 433,466
Total for Top Five Procedures		$ 3,145,225

Radiology expenditures per recipient decreased by seven percent from $1,151 per recipient in SFY 2006 to $1,067 per recipient in SFY 2007, as shown in the following figure.

Figure 2: Radiology Expenditures Per Recipient — SFYs 2006-2007



Reimbursement Methodology

For radiology services (technical and professional component), Wyoming Medicaid pays the lower of the provider's usual and customary charges and a Medicare Relative Value Units (RVUs)–based fee schedule. While the fee schedule was updated in SFY 2007, this update did not apply to all radiology rates. Wyoming Medicaid is in the process of reviewing and updating all radiology rates for

SFY 2008; rates will be 90 percent of Medicare's non-facility fully-implemented Relative Value Unit rates.

Current Issues

Wyoming's rates for the top five procedure codes compare favorably to the rates of surrounding states. The following table shows a comparison of Wyoming Medicaid reimbursement for the professional component of the top five radiology procedure codes to those same procedures codes in states surrounding Wyoming.[58] Following Nebraska, Wyoming's rates are the highest in the surrounding area.

Table 2: Professional Component Fee Schedule Amounts for Top Five Procedure Codes Compared to Other States – SFY 2007

Code	WY	MT	UT	NE	ID
71010	$ 11.03	$ 7.51	$ 7.12	$ 16.00	$ 8.64
71020	14.34	9.15	8.71	20.80	10.70
70450	59.56	34.96	33.54	86.40	41.43
74160	81.62	52.58	49.66	118.40	63.30
74000	11.03	7.51	12.62	16.00	8.84

[58] For certain radiology procedures, there is a technical component service (e.g., the x-ray itself) and a professional component (e.g., the physician's service in reading the x-ray). The professional component fee is the amount paid for the physician's interpretation and report and the technical fee component is the amount paid to provide the service (including staffing and equipment costs).

Table A: Radiology Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 17,173,262	14,736	$ 1,165
2007	14,805,673	13,640	1,085
Percent Change SFYs 2006-2007	-13.8	-7.4	-6.9

RURAL HEALTH CLINIC

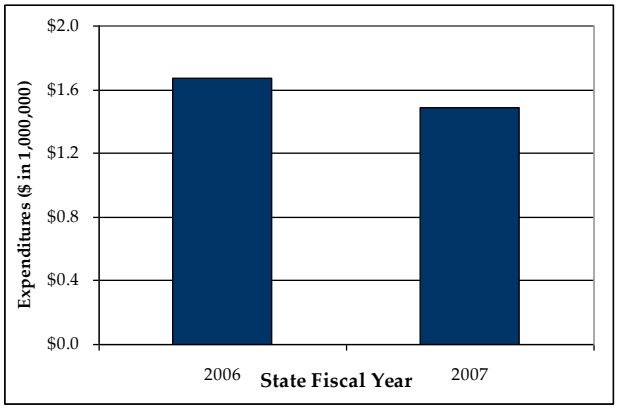
Description

Rural Health Clinic (RHC) services include primary care services, including physician services, services and supplies provided incident to a physician's services, nurse practitioner services, nurse midwife services and physician assistant services. Medicare designates a health clinic as an RHC if it is located in an area designated as a "shortage area". Shortage areas are defined geographic areas designated by the Department of Health and Human Services as having either a shortage of personal health services or a shortage of primary medical care manpower.

Expenditures

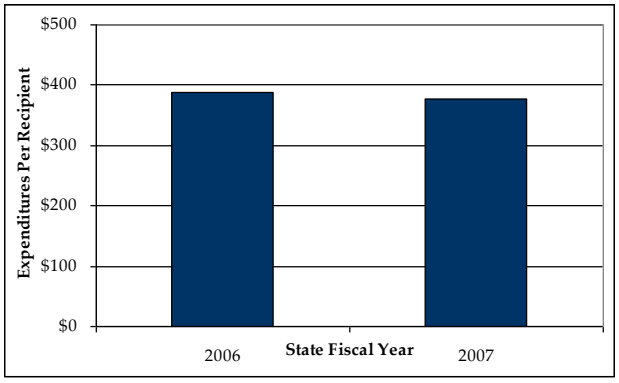
Medicaid RHC expenditures totaled $1.5 million in SFY 2007, an 11 percent decrease from SFY 2006, as shown in the following figure. Four RHCs accounted for the majority of this decrease: Castle Rock, Lusk Medical Clinic, Lusk Satellite Medical Clinic and Oregon Trail. These providers also experienced a decrease in claims volume. RHC expenditures were less than one percent of total Medicaid expenditures in SFY 2007.

Figure 1: RHC Expenditures — SFYs 2006-2007



RHC expenditures per recipient were $378 in SFY 2007, a decrease of three percent from SFY 2006, as shown in the following figure.

Figure 2: RHC Expenditures Per Recipient — SFYs 2006-2007



Reimbursement Methodology

Wyoming Medicaid reimburses RHC claims according to a prospective payment system (PPS) as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). The PPS is based on 100 percent of a facility's average costs during SFY 1999 and SFY 2000. The rates are updated annually for inflation based on the Medicare Economic Index (MEI).

Current Issues

States are required to reevaluate RHC rates should an RHC change its scope of services. Because the PPS has now been in effect for more than five years, Wyoming Medicaid may consider conducting an analysis of current RHC cost report data to assess the need for adjustments to rates to reflect changes, for example, in the scope of services provided by each RHC and how these changes affect the costs of services.

RURAL HEALTH CLINIC

Table A: RHC Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$1,673,934	4,304	$ 389
2007	1,488,588	3,942	378
Percent Change SFYs 2006-2007	-11.1	-8.4	-2.9

VISION

Description

Wyoming Medicaid covers the following vision services for clients age 21 and over:

- Treatment of eye disease or eye injury
- Payment of deductible and/or coinsurance due on Medicare crossover claims for post surgical contact lenses and/or eyeglasses
- Vision therapy for recipients receiving services from the ABI program with qualifying medical diagnosis

Wyoming Medicaid also covers the following vision services for under the age of 21:

- Routine eye examinations, including determination of refractive state
- Office exams as medically necessary for the treatment of eye disease or eye injury
- One pair of eyeglasses, replacement pairs when medically necessary and repairs when no longer under warranty
- One pair of standard frames per 12 month period, up to $76.00
- Corrective lenses
- Contact lenses for the correction of pathological conditions when useful vision cannot be obtained with regular lenses
- Vision therapy

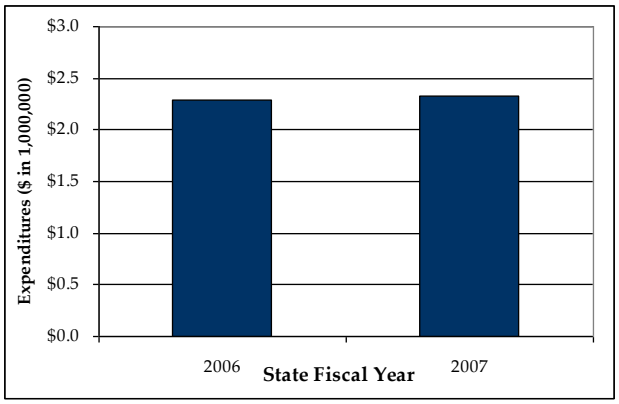
Vision therapy services can be performed by opticians, optometrists and ophthalmologists and are covered services under the ABI waiver.[59] Vision therapy services, as identified by diagnoses codes, are capped at 32 visits per year. Wyoming Medicaid considers additional visits or exceptions to the list of diagnosis codes identified as vision therapy on a case-by-case basis.

[59] Please see the Waiver Habilitation section for more information on the ABI waiver.

Expenditures[60]

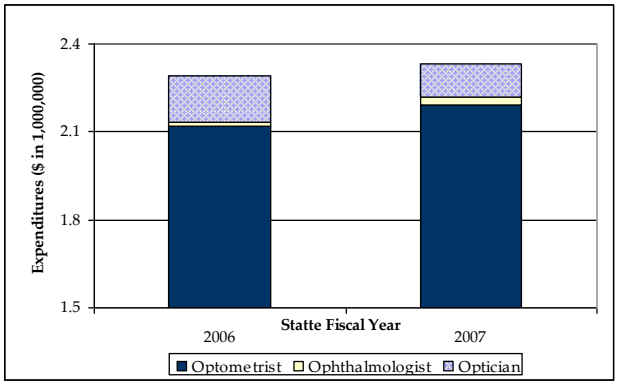
Vision expenditures totaled $2.3 million in SFY 2007, a slight increase of two percent from SFY 2006, as shown in the following figure. These vision expenditures include services performed by optometrists, ophthalmologists and opticians.

Figure 1: Vision Expenditures — SFY 2006-2007



In SFY 2007, 94 percent of vision expenditures were for services provided by optometrists, five percent were for services provided by opticians and one percent was for services provided by ophthalmologists, as shown in the figure below. Vision expenditures were one percent of total Medicaid expenditures in SFY 2007.

Figure 2: Vision Expenditures by Provider Type — SFY 2006-2007

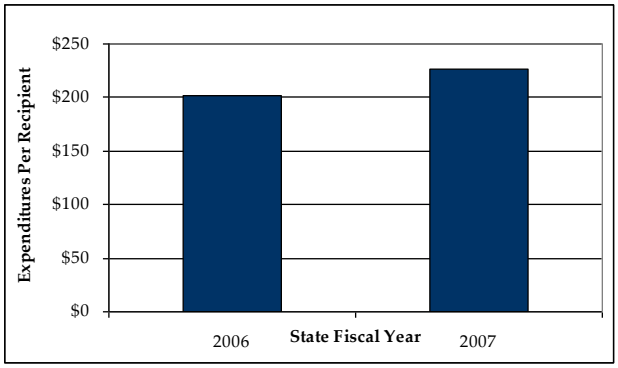


[60] Expenditure data for ophthalmologists includes only expenditures for routine eye exams (V72.0). Other services performed by ophthalmologists are included in the Physician section of the Annual Report.

VISION

Vision expenditures per recipient were $226 in SFY 2007, an increase of 13 percent from SFY 2006, as shown in the following figure.

Figure 3: Vision Expenditures Per Recipient — SFY 2006-2007



Reimbursement Methodology

For ophthalmologists, Wyoming Medicaid pays the lower of the provider's usual and customary charges or the State's Medicaid RBRVS fee schedule.[61] Opticians and optometrists receive the lower of charges or the Wyoming Medicaid fee schedule amount.

Providers bill for vision materials (i.e., frames and lenses) using HCPCS codes. Providers may also bill a dispensing fee for eyeglasses, but they may not receive reimbursement for the dispensing of frames, frame parts or lenses in addition to the eyeglass dispensing fee. Providers may not balance bill the recipient if the recipient chooses frames that are more expensive than the $76 limit set by Wyoming Medicaid, unless there is a written agreement signed by the recipient and the provider.

Current Issues

There are no current issues for this service area.

[61] For more information on the RBRVS fee schedule, refer to the Physician and Other Practitioners Section.

VISION

Table A: Vision Services Total: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 2,289,418	11,383	$ 201
2007	2,331,000	10,301	226
Percent Change SFYs 2006-2007	1.8	-9.5	12.5

Table B: Ophthalmologist Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 12,787	157	$ 81
2007	28,398	240	118
Percent Change SFYs 2006-2007	122.1	52.9	45.3

Table C: Optometrist Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B
2006	$ 2,119,954	10,880	$ 195
2007	2,190,978	9,892	221
Percent Change SFYs 2006-2007	3.4	-9.1	13.7

Table D: Optician Services Only: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 156,677	1,134	$ 13
2007	111,624	717	156
Percent Change SFYs 2006-2007	-28.8	-36.8	12.7

WAIVER HABILITATION

Description

Waiver habilitation services, including residential and day habilitation services, assist individuals with developmental disabilities to improve self-help and socialization skills and skills related to activities of daily living. Individuals receiving services under one of the following Wyoming Medicaid waiver programs may receive residential and day habilitation services:

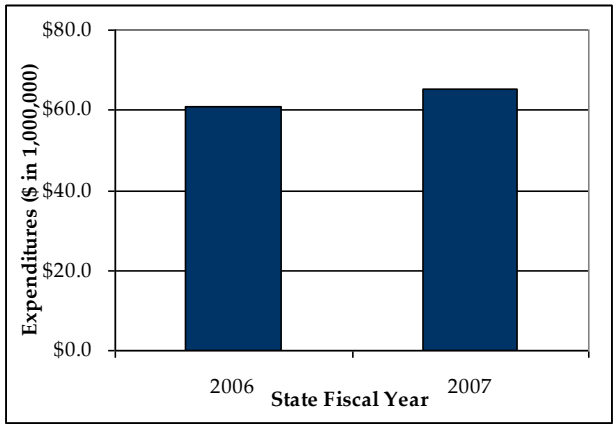
- HCBS Waiver Program for Children with Developmental Disabilities (these children receive residential habilitation only)
- HCBS Waiver Program for Adults with Developmental Disabilities
- ABI HCBS Waiver Program

The waivers also cover supported employment, pre-vocational and other services, which represent approximately 20 to 25 percent of total waiver expenditures. These additional services are not included in this section.

Expenditures

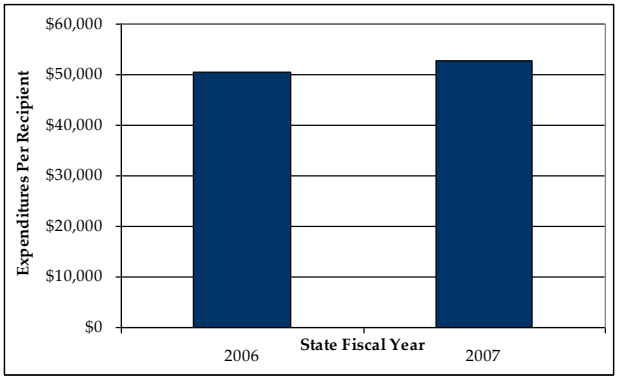
Expenditures for waiver habilitation services totaled $65.3 million in SFY 2007, an 8 percent increase from SFY 2006, as shown in the figure below. Waiver habilitation expenditures were 17 percent of total Medicaid expenditures in SFY 2007.

Figure 1: Waiver Habilitation Expenditures — SFYs 2006-2007



Waiver habilitation expenditures per recipient were $52,694 in SFY 2007, an increase of 4.3 percent from SFY 2006, as shown in the following figure.

Figure 2: Waiver Habilitation Expenditures Per Recipient — SFYs 2006-2007



Reimbursement Methodology

Wyoming Medicaid reimburses for waiver habilitation services as part of each consumer's Individualized Budget Amount (IBA), which covers all waiver services (e.g., case management and personal care, among other services). Under the IBA approach, Wyoming Medicaid allocates a set amount of funding to each consumer based on individual characteristics and his or her service utilization.

Wyoming Medicaid makes its IBA determination using the "DOORS" funding model, which is structured to estimate total individual expenditures based on specific consumer characteristics. The budget establishes, "an amount of funding available for an individual with disabilities to direct and manage the delivery of services she or he is authorized to receive. The amount of the individual budget is derived from a data-based methodology, and is open to inspection and input from the individual receiving support."[62] This approach is

[62] Moseley, Charles R., Robert M. Gettings and Robin E. Cooper. 2005. Having It Your Way: A National Study of Individual Budgeting Practices Within the States. In *Costs and Outcomes of Community Services for People With Intellectual Disabilities*, edited by Roger J. Stancliffe and K. Charlie Lakin, 263-288. Baltimore: Paul H. Brookes Publishing Co.

designed to provide consumers with the flexibility to choose the services they need and allows funding to be portable (i.e., funding follows the individual instead of the provider). Providers negotiate residential and habilitation rates based on consumers' IBAs.

Current Issues

- The Wyoming Department of Health, Division of Developmental Disabilities (the Division) finalized administrative rules for the HCBS waivers at the end of 2006. These rules address eligibility and waiting list requirements, IBA determinations, development of a plan of care, requirements of the Extraordinary Care Committee and certification and sanctioning of providers.
- The Division has also developed and implemented a "Quality Management Strategy" for the three waivers that assesses the quality of waiver services provided throughout the state and assesses the effectiveness of the Division's administration of the waivers. The Strategy, which has been approved CMS, requires that the Division formally compile, analyze and report on data and information relating to the waivers.[63]
- A recent evaluation of the DOORS reimbursement model found:
  - The DOORS Model continues to be considered a part of the emergent national best practices approach to financing services and supports for individuals with developmental disabilities.
  - Consumer satisfaction with the DOORS Model is relatively high, but individual budgets do not offer the consumer-directed decision making that stakeholders expect, either because, in consumers' thinking, the provider and consumer's "team" control service planning or because services are not available.
  - Many consumers are unclear about the objectives and purpose of the DOORS Model, expecting it to fund all needed services rather than equitably distribute funding for services in an approved service plan.[64]
- The Division has conducted a comprehensive evaluation of the application of the "DOORS" model, including a re-evaluation of the current rate setting methodology and the current IBA methodology for establishing funding levels for waiver consumers. It is currently considering merging the IBAs with cost-based reimbursement, but is monitoring how changes in rates may affect the purchasing power of IBAs.
- Many waiver recipients also have mental health issues. According to data collected by the Division through the Inventory for Client and Agency Planning assessment tool, approximately 152 individuals on the adult waiver have a primary or secondary mental health diagnosis. In addition, 27 individuals on the children's waiver and 18 individuals on the ABI waiver have a primary or secondary mental health diagnosis.
- The Division notes that the DOORS model provides a slightly higher IBA amount for individuals with mental health issues because they tend to have higher costs; however, the higher IBA is not intended to cover the mental health needs of this population.
  - The Division has an extraordinary care committee to evaluate requests on a case-by-case basis for additional funding for individuals with extraordinary needs, including those with dual mental health diagnoses. The Division is considering other tools to evaluate extraordinary needs.

[63] Mikesell, C.E. and Malm K., "Report on Developmental Disabilities Division Adult Waiver Program," (October 1, 2006).

[64] Navigant Consulting, Inc., "DOORS Model Evaluation,"(February 23, 2007).

  - There is also a perception that individuals with dual diagnoses may have difficulty having their mental health needs met by CMHCs. CMHCs may not have the resources to address the additional needs of individuals with dual diagnoses or may consider an individual's problem to be more DD related than mental health related.
- The Division also notes that there are workforce shortages in several areas of the State, which limits the ability of providers to accept more clients. One factor contributing to the workforce shortages is competition for staff with the energy extraction industries. Additionally, some of the more rural communities lack providers. The Division has attempted to encourage access and choice by encouraging eligible family members and neighbors to become certified waiver service providers.
- For SFY 2007, there were waiting lists for all three waivers. Although the Legislature has not placed caps on these waivers, funding was not available to support expansion of the waiver

Table A: Waiver Habilitation Services: Expenditures and Recipients by SFY

State Fiscal Year	Expenditures (A)	Number of Recipients (B)	Per Recipient Expenditures (C)=(A/B)
2006	$ 1,277,264	752	$ 1,698
2007	1,545,634	815	1,896
Percent Change SFYs 2006-2007	21.0	8.4	11.7

FOSTER CARE – MEDICAID FUNDED

Description

The foster care program is administered through the Wyoming Department of Family Services (DFS). Foster care provides for the physical and emotional needs of a child until a more permanent plan for the child's well-being can be implemented. Foster care medical coverage is intended to provide for the medical needs of foster children while in the custody of DFS.

According to Section 1902 (a)(10)(A)(i)(I) of the Social Security Act, foster children covered under Title IV-E of the Social Security Act are eligible for Medicaid. In addition, children receiving federally reimbursed adoption subsidies are categorically eligible for Medicaid. Wyoming also extends Medicaid benefits to non- Title IV-E eligible foster children and adopted children supported by state-funded subsidies.

Eligibles and Recipients

The number of foster care Medicaid eligibles increased by two percent from 3,517 in SFY 2006 to 3,573 in SFY 2007. The number of foster care Medicaid recipients increased by 4 percent from 3,080 in SFY 2006 to 3,188 in SFY 2007.

Expenditures

Total Medicaid expenditures for foster care children were $25 million in SFY 2007, an increase of 17 percent from SFY 2006, as shown in the following figure. In comparison, for foster care children who were not eligible for Medicaid, expenditures were $2.4 million in SFY 2007, an increase of 40 percent from SFY 2006. As described below and in the State-funded foster care section of the Annual Report, most of the increase in expenditures appears to be attributable to expenditures for mental health and substance abuse services. Medicaid foster care expenditures are seven percent of total Medicaid expenditures.

Figure 1: Foster Care Expenditures — SFYs 2006-2007

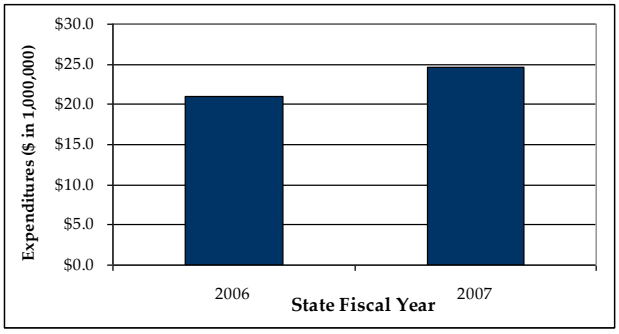


Table 1 on the following page displays SFY 2006 and 2007 expenditures by service area and the percent change between years. In SFY 2007, expenditures for all mental health and substance abuse services totaled $17 million or 70 percent of expenditures for foster care children.[65] Hospital and pharmacy expenditures represent $2.2 million and $2.5 million respectively (9 and 10 percent of total Medicaid foster care expenditures).

Expenditures for three service areas increased by 25 percent from SFY 2006 to 2007: mental health and substance abuse, DMEPOS and ASCs.

Expenditures for ambulance services decreased by 19 percent, as did laboratory at 14 percent, inpatient hospital at 14 percent and radiology at 12 percent. Percentage increases in expenditures for some services areas, such as CORF and home health, were significant; but these expenditures are for a relatively small percent of total Medicaid expenditures.

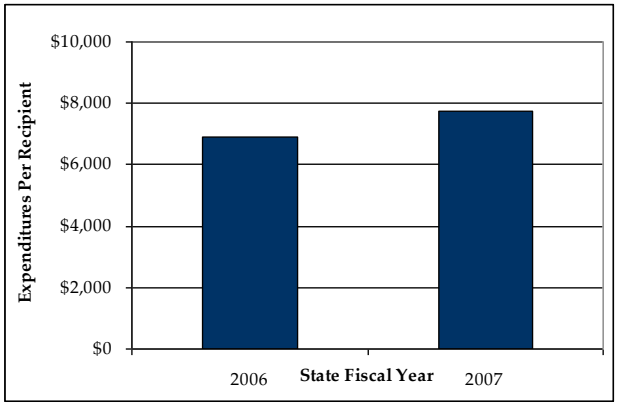
Most of the mental health and substance abuse expenditures were for RTC services. In SFY 2007, expenditures for RTC services were $13 million, or 53 percent of total expenditures for Medicaid foster care recipients. Non-RTC mental health and substance abuse services totaled an additional $4 million in SFY 2007, or 16 percent of total expenditures for Medicaid foster care recipients.

[65] Includes services provided by RTCs, psychiatrists, psychologists, CMHCs and substance abuse rehabilitation.

FOSTER CARE – MEDICAID FUNDED

Health care expenditures per foster care recipient increased by 13 percent from $6,878 in SFY 2006 to $7,784 in SFY 2007, as shown in the following figure.

Figure 2: Foster Care Expenditures Per Recipient — SFYs 2006-2007



Expenditures per recipient for mental health and substance abuse services are also high compared to per recipient expenditures in other service areas, as illustrated in Table 2 on the following page. Per recipient expenditures were $33,130 for RTCs and $2,850 for other mental health and substance abuse services in SFY 2007. Other service areas that had high per recipient expenditures in SFY 2007 were inpatient hospital ($8,963), home health ($1,398) and pharmacy ($1,153).

Expenditures per recipient increased 18 percent from SFY 2006 to 2007 for RTCs and 15 percent for other mental health providers. Expenditures for CORF and home health service areas increased at a high rate from SFY 2006 to 2007, but these expenditures are for a relatively small percent of total Medicaid expenditures. Expenditures for ambulance decreased 13 percent and radiology expenditures per recipient decreased 10 percent from SFY 2006 to SFY 2007.

Current Issues

There are no current issues for this area.

Table 1: Expenditures by Service Area — SFYs 2006-2007 Arrayed by SFY 2007 Expenditures

Service Area	Expenditures SFY 2006	Expenditures SFY 2007	Percent Change
Mental Health Total	$ 13,600,433	$ 17,038,856	25
RTC	*10,356,158*	*12,986,859*	*25*
Other Mental Health and Substance Abuse[66]	*3,244,276*	*4,051,997*	*25*
Prescription Drugs	2,330,513	2,551,963	10
Hospital	2,485,051	2,210,991	-11
Inpatient	*1,961,754*	*1,685,124*	*-14*
Outpatient	*523,297*	*525,867*	*<1*
Dental	605,197	655,545	8
Radiology	380,145	336,244	-12
Vision	222,932	243,187	9
FQHC	90,699	112,693	24
ASC	77,722	96,924	25
DMEPOS	74,970	93,514	25
Physician and Other Practitioners	74,970	93,514	2
RHC	59,605	61,825	4
Ambulance	75,031	60,540	-19
Laboratory	26,966	23,201	-14
Home Health	5,070	16,773	231
Waiver Habilitation	No Expenditures	1,680	N/A
CORF	605	440	-27
Total Expenditures	**$ 21,232,607**	**$ 24,746,859**	**17**

[66] Excludes RTCs and includes CMHCs, psychologists, psychiatrists and stand-alone substance abuse rehabilitation providers.

Table 2: Expenditures per Foster Care Recipient by Service Area — SFYs 2006-2007 Arrayed by SFY 2007 Expenditures Per Recipient

Service Area	Expenditures SFY 2006	Expenditures SFY 2007	Percent Change
Mental Health Total	$ 9,708	$ 11,299	16
RTC	*28,142*	*33,130*	18
Other Mental Health and Substance Abuse	*2,456*	*2,850*	16
Hospital	1,659	1,483	-11
Inpatient	*9,858*	*8,963*	-9
Outpatient	*403*	*404*	<1
Home Health	845	1,398	65
Prescription Drugs	1,050	1,153	10
ASC	936	979	5
DMEPOS	625	678	8
Radiology	659	594	-10
Ambulance	664	577	-13
FQHC	537	505	-6
Physician and Other Practitioners	481	490	2
CORF	303	440	45
Dental	423	440	4
Waiver Habilitation	No Expenditures	336	N/A
RHC	343	325	-5
Vision	215	238	10
Laboratory	76	74	-3

FOSTER CARE – STATE-ONLY FUNDED

Description

The foster care program is administered through the Wyoming DFS. Foster care provides for the physical and emotional needs of a child until a more permanent plan for the child's well-being can be implemented. Foster care medical coverage is intended to provide for the medical needs of foster children while in the custody of DFS.

Wyoming provides medical care for non-Medicaid eligible foster care children through State-only funding. Children in this aid category include those waiting eligibility determination, those who have been verified ineligible and children in correctional institutions.

Eligibles and Recipients

The number of State-only funded foster care eligibles decreased by five percent from 545 in SFY 2006 to 518 in SFY 2007. The number of State-only funded foster care recipients increased by 6 percent from 695 in SFY 2006 to 734 in SFY 2007. In comparison, there were 2,642 Medicaid-funded foster care recipients in SFY 2007. The following table compares eligibles, recipients and expenditures for Medicaid and state-only funded foster care.

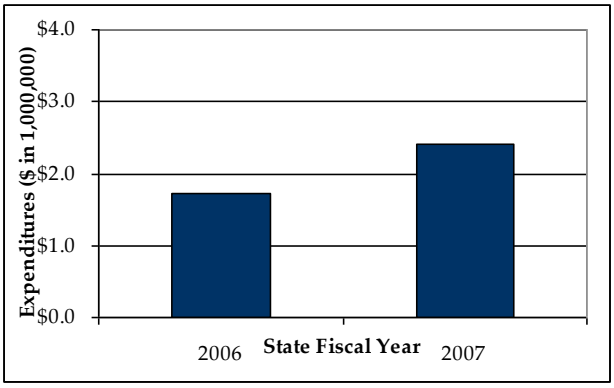
Table 1: Comparison of 2007 Medicaid and State-Only Funded Eligibles, Recipients and Expenditures

Program	Eligibles	Recipients	Expenditures (in Millions)
Medicaid Funded	3,573	3,188	$ 25
State-Only Funded	545	518	2

Expenditures

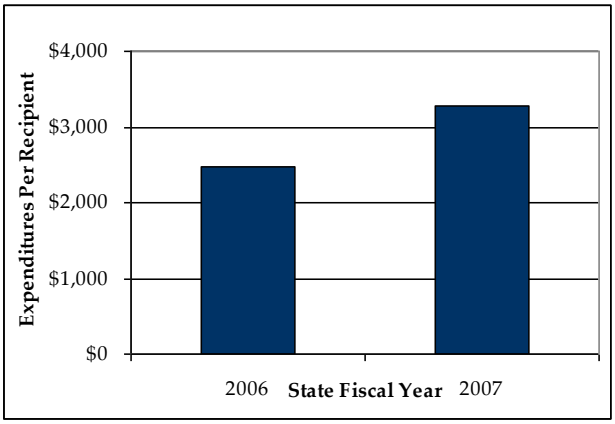
Total State-only expenditures for foster care increased at a higher rate (40 percent) from SFY 2006 to 2007 than expenditures for Medicaid-funded foster care services (17 percent). As described below and in the Medicaid-funded foster care section of the Annual Report, most of the increase in expenditures appears to be attributable to expenditures for mental health and substance abuse.

Figure 1: State-Only Foster Care Expenditures — SFYs 2006-2007



Expenditures per recipient increased by 35 percent from $2,394 in SFY 2006 to $3,241 in SFY 2007, as shown in the following figure.

Figure 2: State-Only Foster Care Expenditures Per Recipient — SFYs 2006-2007



FOSTER CARE – STATE-ONLY FUNDED

The table following displays SFY 2006 and 2007 expenditures by service area for State-funded foster care and the percent change in those expenditures between years. Expenditures for mental health and substance abuse services represented the majority of expenditures in SFY 2007 (61 percent), followed by expenditures for hospital and pharmacy services (12 percent each). [67]

Expenditures for mental health and substance abuse services increased by 73 percent from SFY 2006 to SFY 2007. Expenditures for ambulance and pharmacy services increased 30 percent from SFY 2006 to SFY 2007. Notable decreases in expenditures from SFY 2006 to SFY 2007 include expenditures for radiology services at 45 percent, outpatient hospital at 34 percent and RHCs at 34 percent.

Expenditures for some service areas, like home health and ASC, appear to have grown considerably from SFY 2006 to 2007; however, expenditures for these areas are relatively small as a percentage of total State-funded foster care expenditures.

The majority of the mental health and substance abuse expenditures are for non-RTC mental health and substance abuse providers. In SFY 2007, non-residential treatment center mental health and substance abuse services expenditures were $ .82 million, or 34 percent of State-funded foster care expenditures. Expenditures for RTC services totaled an additional $.64 million, or 27 percent of total expenditures for State-funded foster care recipients.

Table 1: State-funded Foster Care Expenditures by Service Area — SFYs 2006-2007 Arrayed by SFY 2007 Expenditures

Service Area	SFY 2006	SFY 2007	Percent Change
Mental Health Total	$ 845,952	$ 1,462,039	73
RTC	*464,980*	*641,140*	38
Other Mental Health and Substance Abuse	*380,972*	*820,899*	115
Prescription Drugs	223,029	289,188	30
Hospital	262,120	281,254	7
Inpatient	*190,249*	*233,519*	23
Outpatient	*71,871*	*47,734*	-34
Dental	138,297	152,163	10
Physician and Other Practitioners	119,708	107,614	-10
Vision	32,739	41,528	27
Radiology	61,790	33,930	-45
Ambulance	11,086	14,412	30
FQHC	6,450	7,280	13
RHC	8,158	5,407	-34
Home Health	720	4,072	465
Laboratory	2,043	1,854	-9
DMEPOS	1,367	1,380	1
ASC	6,914	567	-92
Total Expenditures	**$ 1,720,375**	**$ 2,402,687**	**40**

[67] Includes services provided by RTCs, psychiatrists, psychologists, CMHCs and substance abuse rehabilitation.

Expenditures per recipient followed similar trends as overall expenditures, as illustrated in Table 2. Expenditures per recipient for RTC services were the highest in SFY 2007 at $11,657, followed by inpatient hospital at $8,052. Expenditures per recipient increased 10 percent from SFY 2006 to 2007 for RTC services and 44 percent for inpatient hospital services. Expenditures per recipient for non-RTC mental health and substance abuse services increased 78 percent from SFY 2006 to SFY 2007.

Home health and ASC expenditures per recipient both had a large percent change from SFY 2006 to 2007, but each service area represents only a small number of recipients. Radiology and DMEPOS service areas' expenditures per recipient decreased notably: 40 and 41 percent respectively from SFY 2006 to SFY 2007.

Current Issues

There are no current issues for this area.

Table 2: Expenditures per State-funded Foster Care Recipient by Service Area — SFYs 2006-2007 Arrayed by SFY 2007 Expenditures Per Recipient

Service Area	SFY 2006	SFY 2007	Percent Change
Mental Health Total	$ 2,619	$ 3,739	43
RTC	*10,568*	*11,657*	10
Other Mental Health and Substance Abuse	*1,229*	*2,183*	78
Hospital	1,016	1,116	10
Inpatient Hospital	5,596	8,052	44
Outpatient Hospital	321	214	-33
Ambulance	792	1,029	30
Home Health	240	1,018	324
Prescription Drug	527	594	13
Ambulatory Surgery Center	1,383	567	-59
Dental	607	525	-13
Radiology	813	485	-40
FQHC	339	303	-11
Physician and Other Practitioners	309	271	-12
Vision	211	237	12
RHC	263	200	-24
DMEPOS	137	81	-41
Laboratory	73	81	10

MEDICARE AND MEDICAID DUAL ELIGIBLES

Description

Medicare and Medicaid dual eligibles are individuals who are entitled to Medicare Part A (hospital coverage) and/or Part B (supplementary coverage) and are eligible for some form of Medicaid benefit.

People age 65 or older and certain disabled persons who have insured status under Social Security are automatically eligible for Medicare Part A. People with Medicare coverage who have limited incomes may also be eligible for Medicaid services. There are various levels of Medicaid assistance available to dual eligibles, depending on income.

For people who meet Wyoming Medicaid eligibility requirements for full Medicaid coverage, Wyoming Medicaid supplements Medicare coverage by providing services and supplies that are available under Wyoming Medicaid (e.g., nursing facility care beyond the 100-day Medicare limit and dental services). Medicare pays first for services that are covered by both programs and Medicaid provides payment for any remaining Medicaid-covered services, up to Wyoming's payment limit.

For individuals who do not qualify for full Medicaid coverage, limited Medicaid benefits are also available to pay for out-of-pocket Medicare cost-sharing expenses for certain other Medicare beneficiaries, for example:

- Qualified Medicare Beneficiaries (QMBs), with resources at or below twice the SSI standard and income at or below 100 percent FPL, receive assistance with Medicare premiums, deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiaries (SLMB -1), with resources at or below twice the SSI standard and income exceeding the QMB level, but less than 120 percent FPL, receive assistance with Medicare Part B premiums.
- SLMB-2 individuals,, who are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program receive assistance with Medicare Part B premiums if their income exceeds the SLMB-1 level, but is less than 135 percent of the FPL.

Eligibles and Recipients

The number of dual eligibles stayed approximately the same from SFY 2006 to SFY 2007 – 8,480 dual eligibles in SFY 2006 as compared to 8,556 in SFY 2007.[68] A larger portion of Medicaid eligibles are non-dual eligibles.

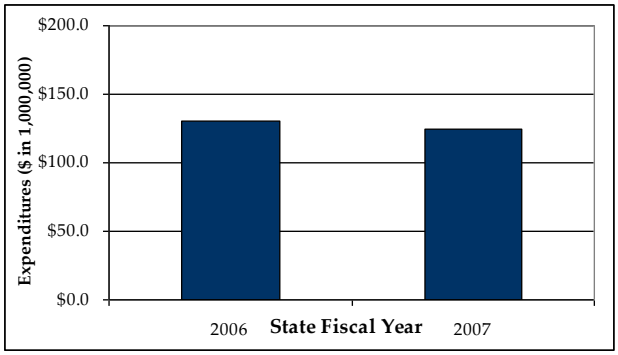
Expenditures

Expenditure and recipient data for dual eligibles include all individuals who are eligible for Medicare and who receive services paid for by Medicaid. For some services, Medicare is the primary payer and Wyoming Medicaid provides additional payments; claims for these services are referred to as crossover claims. Other services for this population are funded entirely through Medicaid, because Medicare does not cover all services. The data described in this section are Medicaid expenditures for both crossover claims and Medicaid-only funded services. The expenditure data described in this section does not include premium assistance for QMB, SLMB-1 and SLMB-2 individuals.

Overall expenditures for dual eligibles were $125 million in SFY 2007, a decrease of four percent from $130 million SFY 2006, as shown in the following figure.

[68] For the purposes of this report, dual eligibles are identified as individuals who are eligible for Medicare and Medicaid and who receive Medicaid services. As such, the number of dual eligibles equals the number of dual eligible recipients. See Appendix A for a description of how dual eligibles were identified.

Figure 1: Expenditures for Dual Eligibles — SFYs 2006-2007



Expenditures per recipient decreased by five percent from $15,343 in SFY 2006 to $14,602 in SFY 2007, as shown in the below figure.

Figure 2: Dual Eligible Expenditures Per Recipient — SFYs 2006-2007

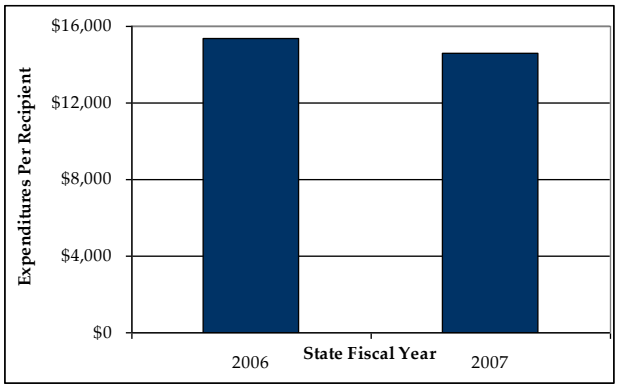


Table 1 on the following page displays SFY 2006 and 2007 expenditures by service area for dual eligibles and the percent change between years.

Ninety-five percent of all expenditures are represented by five service areas: long-term care, waiver habilitation, hospital, physician and other practitioners, and mental health and substance abuse. Hospital, physician and other practitioners and mental health and substance abuse service areas experienced a 10 percent or more increase in expenditures from SFY 2006 to 2007. Expenditures for long-term care services stayed approximately the same between the two years and expenditures for waiver habilitation services increased by eight percent.

The largest decrease in expenditures from SFY 2006 to SFY 2007 was for prescription drug services (87 percent), a result of the implementation of the new Medicare prescription drug benefit.

Table 2 on the following page displays SFY 2006 and 2007 expenditures per recipient by service area for dual eligibles and the percent change between years.

Waiver habilitation services had the highest SFY 2007 expenditures per recipient at $53,092. Expenditures for waiver habilitation services decreased slightly (less than one percent) from SFY 2006 to SFY 2007.

Expenditures per recipient for prescription drugs experienced a notable decrease of 73 percent from SFY 2006 to SFY 2007 due to the implementation of Medicare's new prescription drug benefit. While the dental and laboratory service areas experienced notable percentage changes in expenditures from SFY 2006 to SFY 2007, these service areas represent a very small proportion of total dual eligible Medicaid expenditures.

Current Issues

There are no current issues for this area.

Table 1: Expenditures by Service Area — SFYs 2006-2007, Arrayed by SFY 2007 Expenditures

Service Area	Expenditures SFY 2006	Expenditures SFY 2007	Expenditures Percent Change From SFY 2006
Long-Term Care	$ 58,003,211	$ 58,076,097	<1
Waiver Habilitation	47,208,379	50,915,333	8
Hospital	4,413,407	5,203,950	18
Inpatient	2,422,624	2,916,824	20
Outpatient	1,990,783	2,287,126	15
Physician and Other Practitioners	2,376,817	2,894,614	22
Mental Health and Substance Abuse	2,010,376	2,210,282	10
Prescription Drugs	12,995,499	1,677,675	-87
DMEPOS	1,318,128	1,533,635	16
Home Health	467,078	675,893	45
ESRD	296,552	436,904	47
Hospice	148,897	358,365	141
Radiology	226,943	251,486	11
Dental	65,601	222,082	239
Ambulance	165,686	184,556	11
Vision	159,701	158,712	-1
ASC	98,779	114,530	16
RHC	93,374	104,664	12
FQHC	84,220	77,708	-8
Laboratory	34,476	31,386	-9
CORF	4,524	4,365	-4
Total	**$130,112,671**	**$124,935,619**	-4

Table 2: Expenditures per Recipient by Service Area — SFYs 2006-2007, Arrayed by SFY 2007 Expenditures Per Recipient

Service Area	Expenditures Per Recipient SFY 2006	Expenditures Per Recipient SFY 2007	Expenditures Per Recipient Percent Change From SFY 2006
Waiver Habilitation	$53,829	$53,092	-1
Long-Term Care	23,266	29,272	26
ESRD	5,492	7,405	35
Hospice	6,768	5,875	-13
Home Health	3,860	3,840	-1
Mental Health and Substance Abuse	1,168	1,246	7
Hospital	774	730	-6
Inpatient	1,673	1,814	8
Outpatient	468	414	-11
Prescription Drugs	2,303	632	-73
DMEPOS	525	530	1
Dental	188	289	54
ASC	228	241	6
Ambulance	212	230	8
CORF	188	198	5
RHC	148	148	<1
Physician and Other Practitioners	124	143	15
FQHC	148	122	-18
Vision	82	83	2
Radiology	64	72	11
Laboratory	55	22	-60

Description

The following provides a description of the data sources and the calculations that we used to determine the annual expenditure data included in this Annual Report.

For all services, Navigant Consulting identified annual expenditure data for SFYs 2006 and 2007 by taxonomy using paid claims data from Wyoming Medicaid's claims processing system. Expenditure data represent a picture of total expenditures at a single point in time. Since claims can be adjusted after payment and the claims system is updated regularly, claims data extracted at different times will vary.

We extracted data by provider taxonomy for four subpopulations:

- Medicaid, including Medicaid-funded Foster Care and excluding crossover claims for dual eligibles
- Medicaid-funded Foster Care
- State-only funded Foster Care
- Dual Eligibles, including crossover claims and Medicaid-only funded services

To exclude crossover claims from the Medicaid subpopulation, we excluded the following claims types:

- Outpatient Crossover (claim type code V)
- Inpatient Crossover (claim type X)
- Medicare Part B (claim type B)

For all data extracts, we have excluded third party payments, co-payments and disproportionate share hospital payments. We extracted claims data only for fully or never adjusted claims. We have included gross adjustments. Data extracts no not include expenditures for premium or cost-sharing assistance for Medicare eligible individuals. Exhibit 1 at the end of this section details the data parameters used to extract data for each service area included in the Annual Report. Eligibility criteria used to define our subpopulations follows in this Section.

For some service areas, additional data or calculations were necessary. For inpatient and outpatient services, we used detailed paid claims expenditure data, hospital Medicare cost report data and Wyoming Medicaid's summary of SFY 2007 federal qualified rate adjustment (QRA) payments.[69]

The rest of this Appendix describes the following:

- Eligibility
- Provider taxonomies excluded from the Annual Report analyses
- Additional data and calculations
- Calculations of recipients and expenditures

Eligibility

There are four major categories of eligibility for Wyoming Medicaid, which are described in detail in Section 2 (Overview of Eligibles). We determined the number of eligibles for each of the ten categories using eligibility reports developed by the State's fiscal intermediary, ACS. We excluded program codes N99 (Long-term care screening) and ZZZ (gross adjustments) as well as all non-Medicaid program codes.

We counted an individual as eligible if he or she was eligible at any point in time during the SFY.

We identified dual eligibles with the assistance of a Cognos report developed by ACS. The report included several queries. The first query identified all individuals who are eligible for Medicare. The next query matched this data to Medicaid eligibility data. This data represents the population of dual eligibles. From there we extracted recipient and expenditures data by provider taxonomy for this subpopulation, using the Medicare A/B path in Cognos.

[69] Renee Propps, Facilities Manager, State of Wyoming Office of Medicaid, Electronic mail correspondence (November 13, 2007)

To exclude or include appropriate program groups in our Medicaid and foster care data extracts, we used the Wyoming Eligibility Program Groups, version 9.1. To determine Medicaid expenditures, we excluded claims with the following non-Medicaid eligibility program codes on the claim header level.

Table 1: State-only Program Codes Excluded from the Medicaid Analysis

Program Code Description	Program Code
Basic Foster Care (Temp. for up to 60 days while eligibility is established)	A95
Real Foster Care (Child verified to not be Medicaid eligible)	A96
Foster Care Public Institution (Child in Public Institution, not eligible for Medicaid)	A99
PDAP Prescription Drugs	A90
PDAP Prescription Drugs	A91
SLSC - State Only Program	S26
SLSC - State Only Program	S27
SHP - State Only Program	S28
SHP - State Only Program	S29
Part B - Partial/PDAP Disabled	Q84
Part B - Partial/PDAP Aged	Q85
Part B -100% Fed/PDAP Disabled	Q86
Part B -100% Fed/PDAP Aged	Q87
QMB/PDAP Aged	Q88
QMB/PDAP Disabled	Q89
SLMB/PDAP Aged	Q90
SLMB/PDAP Disabled	Q91
Developmental Disabilities TCM	D99
Breast and Cervical (Not Medicaid Eligible)	B05
CSH, Children's Special Health (Special Needs)	C05
CSH, Children's Special Health (High Risk Mom)	C06
CSH, Children's Special Health (Regular Baby)	C07
CSH, Children's Special Health (Intensive Care Baby)	C08
Marginal Dental - for Children	D01
Maternal Dental - for Expectant Mothers	D05
IMMRX Prescription Drugs	A92
ADAP Prescription Drugs	P01
Kid Care 1 (Program not active)	K01
Kid Care 2 (Program not active)	K02
Low Income Subsidy (LIS) - Application Approved	L01
Low Income Subsidy (LIS) - Application Denied	L02
Unborn Children	A49

Additionally, we excluded program codes for Medicare eligibles who are eligible for cost sharing and premium assistance from Medicaid as displayed in the following table.

Table 2: Medicare Eligible Program Codes Excluded from the Medicaid Analysis

Program Code Description	Program Code
Qualified Medicare Beneficiary	Q17
Qualified Medicare Beneficiary	Q41
Specified Low Income Medicare Beneficiary	Q94
Specified Low Income Medicare Beneficiary	Q95
Specified Low Income Medicare Beneficiary	Q96
Specified Low Income Medicare Beneficiary	Q97
Part B - Partial AMB Aged	Q98
Part B - Partial AMB Disabled	Q99

To determine expenditures for Medicaid-funded and State-only funded Foster Care, we used the program codes listed in Table 3.

Table 3: Foster Care Program Codes

Program Code Description	Program Code
Medicaid Foster Care	A51
Medicaid Foster Care	A85
Medicaid Foster Care	A88
Medicaid Foster Care	A97
Medicaid Foster Care	A98
Medicaid Foster Care	A52
Medicaid Foster Care	A86
State-Only Basic Foster Care (Temporary for up to 60 days while eligibility is established)	A95
State-Only Real Foster Care (Child verified to not be Medicaid eligible)	A96
State-Only Foster Care Public Institution (Child in Public Institution, not eligible for Medicaid)	A99

Provider Taxonomies Excluded from the Annual Report

There are Medicaid expenditures that are not included in the Annual Report. SFY 2007 Medicaid expenditures for services included in the Annual Report represent 93 percent of total Medicaid expenditures ($376, including QRA, as compared to $403 million). The following table lists the provider taxonomies excluded from the Annual Report and the expenditures for SFY 2007.

Table 3: Provider Taxonomies Excluded from the Annual Report

Provider Taxonomy Code	Provider Taxonomy Description	SFY 2007 Expenditures
	Unknown	$ (296,678)
171R00000X	Interpreter	24,154
246RP1900X	Phlebotomy/WY Health Fair	12,911
261QP0904X	Public Health, Federal (Indian Health Services)	5,729,822
315P00000X	ICF/MR (State Training School)	10,358,367
251K00000X	Public Health or Welfare	629,065
999990006X	Non-Medicaid Provider (mail only)[70]	(23,132)
261Q00000X	Clinic/Center (Developmental Center)	620,015
251B00000X	Case Management (Waiver)[71]	10,518,718
261QA0005X	Ambulatory Family Planning Facility	94,452
Total Excluded Expenditures		**$ 27,667,694**

[70] When an insurance company sends a check for a claim not in the system the Department accounts for receipt of the money by bringing it into the MMIS using a dummy provider number, 900000300. The dummy number is assigned taxonomy code 999990006X. John M. Goetz, Deputy Account Manager, ACS Government Healthcare Solutions. Electronic mail correspondence (November 30, 2007).

[71] Recipients in the LTC/HCBS, ALF or DD/ABI waivers may receive case management services. For LTC/HCBS and ALF recipients, these case management services are included in this Report in the non-waiver portion of expenditures. However, these non-waiver expenditures are not included in the total Medicaid expenditures described in Section 1 (introduction). For waiver habilitation recipients, we did not include discussion of non-waiver services. Case management services for these recipients are not included in this Report.

Additional Data or Calculations

Ambulance

We allocated expenditures between ground and air services based on the procedure code associated with each claim line. Most procedure codes apply only to either ground or air service, but procedure codes A0382, A0398, A0422 and A0998 include both air and ground expenditures.

To allocate expenditures for air expenditures for these four procedure codes, we:

- Calculated the total expenditures for ground-only procedure codes and the total expenditures for air-only procedure codes.
- Calculated the percentage that air-only expenditures comprise of all air-only and ground-only expenditures.
- Multiplied total expenditures for procedure codes A0382, A0398, A0422 and A0998 by the air-only percentage and added the result to the air-only ambulance expenditures.

To allocate expenditures for ground expenditures for these four procedure codes, we:

- Calculated the total expenditures for ground-only procedure codes and the total expenditures for air-only procedure codes
- Calculated the percentage that ground-only expenditures comprise of all air-only and ground-only expenditures
- Multiplied total expenditures for procedure codes A0382, A0398, A0422 and A0998 by the ground-only percentage and added the result to the ground -only ambulance expenditures.

Inpatient Hospital

We used the following data from Wyoming Medicaid's SFY 2007 Qualified Rate Adjustment payment analysis, in combination with additional data from out-of-state hospitals, to estimate cost coverage and budget impacts:

- Fully adjudicated inpatient hospital claim line items with dates of payment in SFY 2007 (extracted from Wyoming's Decision Support System using Navigant Consulting's remote connection). This includes claims for the inpatient levels of care as well as claims for transplants, extended psychiatric and specialty rehabilitation services. For the Qualified Rate Adjustment analysis, we inflated payments, including TPL, to SFY 2007 levels using the inpatient level of care inflation amounts. For this Annual Report, we adjusted this estimated inflated payment amount to exclude TPL. We made this adjustment by multiplying the inflated payment by the percentage of the uninflated payment that non-TPL payments comprise.
- As-filed cost report data for all in-state providers and out-of-state participating providers.
- Federal share of Wyoming Medicaid's QRA payments.

We included estimated costs of payments for medical education and capital. We estimated inpatient hospital costs for providers for which we did not collect cost report data by using the average cost-to-charge ratio from providers with cost report data.

Unless indicated otherwise, expenditures and cost coverage provided in the inpatient hospital narrative represents in-state and out-of-state participating providers.

A participating provider is defined as all hospitals within Wyoming that are providers, and all out-of-state hospitals that were paid $250,000 or more by the Wyoming Medicaid program during the period from July 1, 1994, through December 31, 1996. Participating providers include all rehabilitation facilities and psychiatric hospitals that received Wyoming Medicaid funds during the period from July 1, 1994, through December 31, 1996.

Outpatient Hospital

To estimate cost coverage and budget impacts for this strategic plan, we used Wyoming Medicaid's SFY 2007 Qualified Rate Adjustment payment analysis, in combination with additional data from out-of-state hospitals. We used the results of Wyoming Medicaid's SFY 2007 Qualified Rate Adjustment payment analysis as follows:

- Fully adjudicated outpatient hospital paid claims line items with dates of payment in SFY 2007 (extracted from Wyoming's Decision Support System using Navigant Consulting's remote connection)
- Cost report data (as-filed 2006 cost reports) used for the analysis of inpatient hospital services
- Federal share of Wyoming Medicaid's actual QRA payments

Outpatient payments were not inflated. We estimated outpatient costs for providers for which we did not collect cost report data by using average cost-to-charge ratios from providers with cost report data.

Calculations for Expenditure and Recipient Figures

- Per recipient expenditures – Equal to the total expenditures for each fiscal year divided by the number of unique recipients for each fiscal year. We determined the number of unique recipients by counting the number of unduplicated recipients who received services in each state fiscal year.
- Percentage change in total expenditures – Represents the increase in total expenditures for each year based on the percent change of total expenditures from one SFY to the next.
- Percentage change in per recipient expenditures – Represents the increase in per recipient expenditures for each year based on the percent change of per recipient expenditures from one SFY to the next.

Specific Service Line Notes

- Percentage change in level of care payments for inpatient hospital services – Represents the percent increase in provider rates for each year due to updates to the level of care rates for the Wyoming Medicaid program.

Exhibit 1: Annual Report Data Parameters

Service Area	Provider Taxonomy	Claim Adjustment Status Code	Claim Type Code[72]	Cognos Path
Assisted Living Facility (ALF) Waiver (total waiver and non-waiver services)	Recipient program codes = R01, R02, R03, R04	0, F	Excluded B, V	>Paid Claims >All Claims
ALF Waiver (waiver services only)	251B00000X: Long-Term Waiver Recipient program codes = R01, R02, R03, R04	0, F	Excluded B, V	>Paid Claims >All Claims
ALF Waiver (non-waiver services only)	Excluded 251B00000X: Long-Term Waiver Recipient program codes = R01, R02, R03, R04	0, F	Excluded B, V	>Paid Claims >All Claims
Ambulance (total)	341600000X: Ambulance	0, F	Excluded B, V	>Paid Claims >Medical claims
Ambulance (air)	341600000X: Ambulance Procedure Codes: A0030, A0430, A0431, A0435, A0436; A0382, A0398, A0422 and A09981[73]	0, F	Excluded B, V	>Paid Claims >Medical claims
Ambulance (ground)	341600000X: Ambulance Procedure Codes: A0221, A0360, A0362, A0368, A0370, A0380, A0390, A0425, A0426, A0427, A0428 and A0429; A0382, A0398, A0422 and A09981[1]	0, F	Excluded B, V	>Paid Claims >Medical claims
ASC	261QA1903X: Ambulatory Surgery Center	0, F	Excluded B, V	>Paid Claims >All Claims
CORF	261QR0401X: Rehabilitation, Comprehensive Outpatient Rehabilitation	0, F	Excluded B, V	>Paid Claims >All Claims
Dental	1223G0001X: General Practice 122300000X: Dentist 1223X0400X: Orthodontics 1223P0221X: Pedodontics	0, F	D, G	>Paid Claims > Dental claims

[72] The claim type code and Cognos path parameters do not apply to dual eligibles.
[73] These procedure codes apply to both air and ground ambulance services. We split the expenditures for these procedure codes among air and ground ambulance services by 1) first determining the percent of ambulance expenditures, without expenditures for these procedure codes, that the State spent on air versus ground services and then 2) applying these percentages to the total expenditures for these procedure codes.

Service Area	Provider Taxonomy	Claim Adjustment Status Code	Claim Type Code[72]	Cognos Path
	1223P0300X: Periodontics			
	1223S0112X: Surgery, Oral and Maxillofacial 1223E0200X: Endodontics			
DMEPOS (total)	3312B00000X: DME 335E00000X: POS	0, F	Excluded B, V	>Paid Claims >All Claims
DMEPOS (DME only)	3312B00000X: DME	0, F	Excluded B, V	>Paid Claims >All Claims
DMEPOS (POS only)	335E00000X: POS	0, F	Excluded B, V	>Paid Claims >All Claims
ESRD	261QR0401X: End-Stage Renal Disease	0, F	Excluded B, V	>Paid Claims >All Claims
FQHC	261QF0400X: Federally Qualified Health Center	0, F	Excluded B, V	>Paid Claims >All Claims
Home Health	251E00000X: Home Health	0, F	Excluded B, V	>Paid Claims >All Claims
Hospice Care	251G00000X: Hospice Care, Community Based	0, F	Excluded B, V	>Paid Claims >All Claims
Laboratory	291U00000X: Clinical Medical Laboratory	0, F	Excluded B, V	>Paid Claims >All Claims
Long-Term Care Waiver (waiver services only)	251B00000X: Long-Term Waiver Recipient program codes = S24, S25, S46, S 47	0, F	Excluded B, V	>Paid Claims >All Claims
Long-Term Care Waiver (non-waiver services only)	Excluded 251B00000X: Long-Term Waiver Recipient program codes = S24, S25, S46, S 47	0, F	Excluded B, V	>Paid Claims >All Claims
Long-Term Care Waiver (total waiver and non-waiver services)	Recipient program codes = S24, S25, S46, S 47	0, F	Excluded B, V	>Paid Claims >All Claims

Service Area	Provider Taxonomy	Claim Adjustment Status Code	Claim Type Code[72]	Cognos Path
Total Mental Health and Substance Abuse	Provider Taxonomy: 2084P0800X: Psychiatrist, 103TC0700X: Clinical Psychologist, 364SP0808X: NP, APN Psychiatric/Mental Health, 261QM0801X: Mental Health - Including Community Health Center, 101YP2500X: Professional Counselor, 261QR0405X: Rehabilitation, Substance Use Disorder, 323P00000X: Hospital Based RTC Facility, 322D00000X: Freestanding Psychiatric RTC	0, F	Excluded B, V	>Paid Claims >All Claims
Mental Health and Substance Abuse: RTCs only	323P00000X: Hospital Based RTC Facility 322D00000X: Freestanding Psychiatric RTC	0, F	Excluded B, V	>Paid Claims >All Claims
Mental Health and Substance Abuse: Community Mental Health and Substance Abuse Centers, Mental Health and Substance Abuse Providers	Provider Taxonomy: 2084P0800X: Psychiatrist, 103TC0700X: Clinical Psychologist, 364SP0808X: NP, APN Psychiatric/Mental Health, 261QM0801X: Mental Health - Including Community Health Center, 101YP2500X: Professional Counselor, 261QR0405X: Rehabilitation, Substance Use Disorder	0, F	Excluded B, V	>Paid Claims >All Claims
Mental Health and Substance Abuse: Dual Mental Health and Substance Abuse Diagnoses	Provider Taxonomy: 2084P0800X: Psychiatrist, 103TC0700X: Clinical Psychologist, 364SP0808X: NP, APN Psychiatric/Mental Health, 261QM0801X: Mental Health - Including Community Health Center, 101YP2500X: Professional Counselor, 261QR0405X: Rehabilitation, Substance Use Disorder Substance Abuse Diagnoses Codes: 291 - 292.9; 303 - 305.9 **AND** Mental Health Diagnoses Codes: 290 - 290.9; 293 - 302.9; 306 - 311	0, F	Excluded B, V	>Paid Claims >All Claims
Mental Health Only	Provider Taxonomy: 2084P0800X: Psychiatrist, 103TC0700X: Clinical Psychologist, 364SP0808X: NP, APN Psychiatric/Mental Health, 261QM0801X: Mental Health - Including Community Health Center, 101YP2500X: Professional Counselor Mental Health Diagnoses Codes: 290 - 290.9; 293 - 302.9; 306 - 311	0, F	Excluded B, V	>Paid Claims >All Claims
Mental Health Waiver	Recipient Program Codes: S95, S96	0,F	W	>Paid Claims >All Claims
Nursing Home Expenditures	314000000X: Skilled Nursing Facility 275N00000X: Medicare Defined Swing Bed	0, F	N, G	>Paid Claims >All Claims
Physicians and Other Practitioners (physicians)	The physician taxonomies included all taxonomies starting with '20' and the physician assistant '363A00000X' taxonomy. The physician taxonomies do not include 2084P0800X: psychiatrists. Procedure codes: exclude routine vision services.	0, F	M, G	>Paid Claims >All Claims

Service Area	Provider Taxonomy	Claim Adjustment Status Code	Claim Type Code[72]	Cognos Path
Physicians and Other Practitioners (other practitioners)	Occupational Therapist: 225X00000X, Physical Therapist: 22510000X, Podiatrist: 213E00000X, Nurse Practitioner: 363L00000X, 363LA2200X, 363LF0000X, 363LG0600X, 363LX0001X, 363LP0200X, Nurse Midwife: 367A000000X, Nurse Anesthetist: 367500000X	0, F	M, G	>Paid Claims >All Claims
Pharmacy	333600000X: Pharmacy	0, F	P, G	>Paid Claims >All Claims
Radiology	Any provider taxonomy (except physician taxonomies) Procedure Codes: between 70000 and 80000.	0, F	Excluded B, V	>Paid Claims >All Claims
RHC	261QR1300X: Rural Health Clinic	0, F	Excluded B, V	>Paid Claims >All Claims
Vision	156FX1800X: Optician, 207W00000X: Ophthalmologist, 152W00000X: Optometrist Procedure codes: limited to routine vision services for ophthalmologists	0, F	Excluded B, V	>Paid Claims >All Claims
Waiver Habilitation	251C00000X-DD Waiver Recipient Program Codes: B01, B02, S22, S23, S44, S45, S93, S94 Procedure Codes: W2107, W2111, W3015, T2016, T2020, T2033, W3011, W3111, W3115		Excluded B, V	>Paid Claims >Medical claims

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Ambulance	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. Fee schedule developed in 1989 based on comparison to Medicare's fees. • Fixed fee schedule amount for transport. • Mileage and disposable supplies billed separately. • Separate fee schedules for basic life support (ground); advanced life support (ground); additional advanced life support (ground) and air ambulance.	No change.	• Rates for basic life support and advanced life support (ground) updated based on comparison to rates of surrounding states (effective July 1, 2004)	No change.	• All air ambulance codes updated based on comparison to rates of surrounding states (effective January 1, 2006). • Mileage for air ambulance increased to $11.20 per mile.	No change.
Ambulatory Surgery Centers (ASCs)	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. Fee schedule established in 1989 using Medicare's rates and subsequently updated to reflect October 1, 1992 Medicare national rates.	No change.	No change.	No change.	No change.	• Fees increased to 90 percent of Medicare's 2007ASC rates (effective January 1, 2007).

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Children's Mental Health HCBS Waiver	N/A[74]	N/A	N/A	N/A	N/A	• Lower of the provider's usual and customary fee or the Medicaid fee schedule. • Procedure code-based rates developed based on rates for community mental health services and other comparable providers.
Community Mental Health Centers and Mental Health and Substance Abuse Professionals	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Fee schedule established by the Mental Health Division and the Substance Abuse Division. • Updated in July 2002.	No change.	No change.	No change.	No change.	• Legislated and funded rate increase of 24 percent from $70 per hour to $87 per hour. • State portion of the increase effective July 1, 2007. Federal match effective September, 2007.

[74] The children's mental health waiver was a new program implemented in July 2006.

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Comprehen-sive Outpatient Facility (CORF)	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Last updated the fee schedule in 1994.	No change.	No change.	No change.	No change.	No change.
Dental	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • In July 2000, dental fees updated to: ➢ Top 20 procedures: Higher of the fee schedule or 90 percent of the average charge in SFY 1999. ➢ All other procedures: 85 percent of the average charge in SFY 1999.	No change.	• Legislated and funded fee increase to the 75th percentile of usual and customary charges (effective September 2004).	No change.	No change.	No change.

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Durable Medical Equipment, Prosthetics and Orthotics	• Lower of the fee schedule, or the provider's usual and customary charges for each HCPCS code. Wyoming Medicaid uses Medicare's fee schedule, which is updated annually for inflation based on the consumer price index. For procedure codes not on Medicare's list, Wyoming Medicaid considers other states' rates. • Certain DME, e.g., customized wheelchairs, is manually priced based on the manufacturer's invoice price, plus a 15 percent add-on, plus shipping and handling.	• Fees updated annually per Medicare's inflation increases. • Updates to fee schedule for certain services that are manually priced.	• Fees updated annually per Medicare's inflation increases.	• Fees updated annually per Medicare's inflation increases.	• Fees updated annually per Medicare's inflation increases. • For mileage related to DME deliveries, increase to $.40 per mile for deliveries over 50 miles round trip (effective October 2005).	• Fees updated annually per Medicare's inflation increases. • Currently reviewing rates for codes that have not been updated since SFY 2003 (i.e., procedure codes not included in the Medicare fee schedule).
End Stage Renal Disease Services	• Lower of the Medicaid fee schedule or the provider's usual and customary charges. • Last update was in 1994.	No change.	No change.	No change.	No change.	No change.

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Federally Qualified Health Centers	• Prospective per visit payment system implemented on January 1, 2001 as required by the Benefits Improvement and Protection Act (BIPA) of 2000. ➢ Based on 100 percent of a facility's average costs during SFYs 1999 and 2000. ➢ Rates updated annually for inflation based on the Medicare Economic Index (MEI). • Prior to January 1, 2003, the State reimbursed FQHCs and RHCs using Medicare's rates.	• Updated based on MEI (3.0 percent).	• Updated based on MEI (2.9 percent).	• Updated based on MEI (3.1 percent).	• Updated based on MEI (2.8 percent).	• Updated based on MEI (2.1 percent).

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Home Health	• Lower of the submitted charge or the current Medicaid fee schedule. • Rates set in 1989, based on Medicare's rates.	No change.	No change.	No change.	No change.	• Effective July 1, 2006, legislated and funded per-visit rate increase of 30 percent from $64 per visit to $84 per visit for skilled nursing, physical therapy, speech therapy, occupational therapy home health aid and medical social workers.
Hospice	• Lower of the current Medicaid fee schedule or the provider's usual and customary charges. • Fees based on Medicare rates. Medicare pays a per-diem amount based on level of care and updates fees annually based on inflation. • For nursing facilities that provide hospice services, payment is 95 percent of the facility's Medicaid per diem rate and is made to the hospice in lieu of the nursing facility reimbursement.	• Fees updated annually per Medicare's inflation increases.	• Fees updated annually per Medicare's inflation increases.	• Fees updated annually per Medicare's inflation increases.	• Fees updated annually per Medicare's inflation increases.	• Fees updated annually per Medicare's inflation increases.

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Inpatient Hospital	• Prospective level of care (LOC) rate per discharge implemented on July 1, 1994 and rebased in 1998. Services paid outside of the LOC system are: ➢ Extended psychiatric and specialty rehabilitation services (as opposed to general rehabilitative services) paid using a negotiated per diem fee schedule. ➢ Transplant services are paid at 55 percent of billed charges. • Hospitals that serve a disproportionate share of low-income patients receive disproportionate share hospital (DSH) payments. • Prior to May 2001 extended psychiatric, specialty rehabilitation, transplant, neonatal intensive care and maternal fetal monitoring services paid through selective contracting under a federal waiver.	• LOC rates updated for inflation using the Medicare inpatient prospective payment (PPS) inflation rates (3.2 percent).	• LOC updated for PPS (3.4 percent).	• LOC updated for PPS (3.0 percent). • Wyoming Medicaid implemented a Qualified Rate Adjustment (QRA) program on July 4, 2004 to provide supplemental payments to non-state governmental hospital.	• LOC updated for PPS (3.2 percent). • Qualified Rate Adjustment (QRA) program provided supplemental payments to non-state governmental hospitals.	• LOC updated for PPS (3.4 percent). • Qualified Rate Adjustment (QRA) program provided supplemental payments to non-state governmental hospitals.

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Laboratory	• Lower of the fee schedule or the provider's usual and customary charges. • Fees updated annually according to Medicare updates.	• Fees updated annually according to Medicare updates.	• Fees updated annually according to Medicare updates.	• Fee schedule updated in 2005 for all codes.	• Fees updated annually according to Medicare updates.	• Fees updated annually according to Medicare updates. • Analyzing and updating all laboratory procedure codes for SFY 2008 based on 90 percent of Medicare's fees.
Long-Term Care and Community Based Services and Assisted Living Facility Waivers	• Based on a fee schedule developed by the Developmental Disabilities Division and Aging Division. • Fees limited to a monthly or yearly cap per person, according to the established care plan.	No change.	No change.	No change.	No change.	• For the long-term are waiver, legislated and funded rate increase to $20 for personal care attendant. Self-directed services rates increased to $12.
Nursing Facility	• Prospective per diem rate with rate components for capital cost, operational cost and direct care costs. • Rates updated annually based on analysis of Medicaid cost reports.	• Rates updated annually based on analysis of Medicaid cost reports.	• Rates updated annually based on analysis of Medicaid cost reports.	• Rates updated annually based on analysis of Medicaid cost reports.	• Rates updated annually based on analysis of Medicaid cost reports.	• Rebased rates using 2004 cost data. • Total increase of $4.2 million legislated and funded.

APPENDIX B: WYOMING EQUALITYCARE RATE HISTORY SFY 2002 THROUGH SFY 2007

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Outpatient Hospital	• Bundled, prospective fee schedule approach for surgical outpatient hospital services (July 1, 1994); each surgical procedure code is assigned to one of 16 bundled payment groups modeled after Medicare's Ambulatory Surgery Center groupings. • Radiology and laboratory services paid according to procedure codes • Other "standalone" services paid the lower of charges and a revenue code-based fee schedule. • Critical access hospitals excluded from system on October 1, 2001, and paid 70 percent of billed charges.	• Department did not update rates through either inflation adjustments or recalculation but did update fee schedule amounts for certain services, such as laboratory, when Medicare updates its professional services fee schedule.	• Department did not update rates through either inflation adjustments or recalculation but did update fee schedule amounts for certain services, such as laboratory, when Medicare updates its professional services fee schedule.	• Department did not update rates through either inflation adjustments or recalculation but did update fee schedule amounts for certain services, such as laboratory, when Medicare updates its professional services fee schedule. • Qualified Rate Adjustment (QRA) program to provide supplemental payments to non-state governmental programs implemented (July 1, 2004).	• Outpatient prospective payment system based on Medicare's Ambulatory Payment Classifications (APCs) system implemented (October 2005). APCs used to pay for significant outpatient procedures, ancillary services, drugs, laboratory services, radiology, selected DME, prosthetics and orthotics, and vaccines and immunizations not paid under Medicaid's physician's fee schedule. Other outpatient hospital services paid the lower of charges and Medicaid's fee schedule. • Initial conversion factors: General hospitals - $44.28; Critical access hospitals - $116.60; Children's hospitals- $101.75. • Qualified Rate Adjustment (QRA) program provided supplemental payments to non-state governmental hospitals.	• Increased conversion factors so that the Calendar Year 2007 conversion factors equal the same percentage of the Medicare conversion factors as they did when Wyoming Medicaid initially implemented the system: General hospitals - $46.10; Critical access hospitals - $120.48; Children's hospitals- $105.11 (effective January 1, 2007). • Qualified Rate Adjustment (QRA) program provided supplemental payments to non-state governmental hospitals.

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Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Prescription Drugs	• Lower of the estimated acquisition cost (EAC) of the ingredients plus the dispensing fee and the provider's usual and customary charge (effective 2001). • EAC is the Average Wholesale Price (AWP) minus 11 percent. • Dispensing fee is $5.00 per prescription. • AWP is determined by pricing information supplied by pharmaceutical manufacturers, distributors and suppliers and is updated monthly. Some drugs are priced by the State Maximum Allowable Cost (SMAC).	No change.	• Department implemented a preferred drug list, which by late 2005 included nine drug groups.	• Implementation of co-payments as follows: $1.00 for generics, $2.00 for preferred drug list brand medications and $3.00 for other brand medications (nursing home clients, pregnant clients and clients less than 21 years of age are exempt).	• Medicare voluntary prescription drug benefit implemented (January 1, 2006), providing prescription drug coverage to persons who are dually eligible for Medicare and Medicaid.	No change.

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Physicians/ Practitioners	• Prior to SFY 2003, lower of the provider's usual and customary charges or the Medicaid physician fee schedule. • Fee schedule was established in July 1989. • Payments for anesthesiologists based on relative weights developed and published by McGraw-Hill.	• Lower of the provider's usual and customary charges or the Resource-Based Relative Value System (RBRVS)-based fee schedule (effective July 1, 2002). Fee schedule based on Medicare 2002 Relative Value Units (RVUs) and a conversion factor of $32.90. • Payments for anesthesiologists did not change.	No change.	• Adopted 2004 Medicare RVUs (August 1, 2004). • Increased conversion factor by $3.30 to $36.20. • Increased payments for selected obstetric and neonate services to 90 percent of usual and customary charges. • Legislated and funded rate increase for selected obstetric and neonate services to 90 percent of usual and customary charges, effective July 1, 2004.	• Payments for anesthesiologists based on relative weights developed and published by the American Society of Anesthesiologists.	• Adopted Medicare 2006 RVUs (January 1, 2007). • Increased conversion factor by $7.63 to $43.83 for physician services (January 1, 2007). • Increased the conversion factor for anesthesiologists by $15.20 to $36.20 for selected obstetric codes (January 1, 2007).
Radiology	• Lower of the provider's usual and customary charges and a Relative-Value Unit (RVU) –based fee schedule implemented in 1990. • Last conversion factor update in 1994.	No change.	No change.	No change.	No change.	• Updated in 2007, but update did not apply to all radiology rates. • Wyoming Medicaid is in the process of reviewing and updating all radiology rates.

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
						• Fees for SFY 2008 will be based on 90 percent of Medicare's non-facility fully-implemented Relative Value Unit rates.
Residential Treatment Services	• All inclusive per diem rate negotiated separately for each provider. • Wyoming Medicaid used Department of Family Services RTC rates and provider financial data to negotiate rates. • No set approach to increase rates.	No change.	No change.	No change.	No change.	The Department conducted a two-year cost study, commencing in 2005, to review the current rates paid to in-state and out-of-state RTC providers. Based on the results of this study, Department is considering updating the rates for SFY 2009.

Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
RHCs	• Prospective per visit payment system implemented on January 1, 2001 as required by the Benefits Improvement and Protection Act (BIPA) of 2000. ➢ Based on 100 percent of a facility's average costs during SFYs 1999 and 2000. ➢ Rates updated annually for inflation based on the Medicare Economic Index (MEI). • Prior to January 1, 2001, the State reimbursed FQHCs and RHCs using Medicare's rates.	• Updated based on MEI (3.0 percent).	• Updated based on MEI (2.9 percent).	• Updated based on MEI (3.1 percent).	• Updated based on MEI (2.8 percent).	• Updated based on MEI (2.1 percent).
Vision	• Prior to SFY 2003, lower of the provider's usual and customary charges or the Medicaid physician fee schedule. • Fee schedule established in July 1989. • Lenses are billed by invoice	• Reimbursement for optometrists and ophthalmologists is lower of the Medicaid RBRVS fee schedule or the provider's usual and customary charges.	No change.	• Frames allowable fee updated to $76.	No change.	No change.

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Service Area	SFY 2002 and Previous	SFY 2003	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Waiver Habitation Services (Adult, Child and ABI)	• Individualized budget amount determined by the "DOORS" funding model, which estimates individual expenditures based on specific customer characteristics. • Payment for specific residential and day habilitation services is made on a per diem basis and varies by provider and consumer. • Consumers negotiate rates based on their budget amount.	No change.	No change.	No change.	No change.	• Effective July 1, 2006, rates updated for direct professional services only.